Anthem Blue Cross and Blue Shield Centennial (PPO) Plan for the State of Colorado

2004
Certificate of Coverage

www.Anthem.com
Customer Service (800) 843-5621 or (303) 831-2384

Colorado Health Plan Description Form
Anthem Blue Cross and Blue Shield
Centennial (PPO) Plan for the State of Colorado
Effective January 1, 2004

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred provider plan
2. OUT-OF-NETWORK CARE COVERED?[1]	Yes, but patient pays more for out-of-network care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage.

	IN-NETWORK	OUT-OF-NETWORK
4. ANNUAL DEDUCTIBLE **Individual** **Family**	 $2,000 $4,000 for all family members	 $4,000 $8,000 for all family members
5. OUT-OF-POCKET ANNUAL MAXIMUM[2]	$5,000 + Deductible individual or $10,000 + Deductible family The in-network out-of-pocket maximum is not applied towards the out-of-network out-of-pocket maximum. Eligible changes for Other Mental Health Care and Alcohol and Substance Abuse are included in the out-of-pocket annual maximum.	$10,000 + Deductible individual or $20,000 + Deductible family The out-of-network out-of-pocket maximum is not applied towards the in-network out-of-pocket maximum. Eligible changes for Other Mental Health Care and Alcohol and Substance Abuse are included in the out-of-pocket annual maximum.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum	No lifetime maximum
7A. COVERED PROVIDERS	PPO Provider Network. See provider directory for complete list.	All providers licensed or certified to provide covered benefits.
7B. WITH RESPECT TO NETWORK PLANS, ARE ALL THE PROVIDERS LISTED IN 7A. ACCESSIBLE TO ME THROUGH MY PRIMARY CARE PHYSICIAN?	Yes	Not applicable
8. ROUTINE MEDICAL OFFICE VISITS	80% after deductible	60% after deductible
9. PREVENTIVE CARE **a) Children's Services** **b) Adult's Services**	 80% not subject to deductible (up to age 13) 80% after deductible	 60% not subject to deductible (up to age 13) 60% after deductible
10. MATERNITY **a) Prenatal care** **b) Delivery & inpatient well baby care**	 80% after deductible 80% after deductible	 60% after deductible 60% after deductible

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS **Level of coverage and restrictions on prescriptions**		
a) Inpatient care	80% after deductible	60% after deductible
b) Outpatient care	Tier 1 generic formulary $15, tier 2 brand formulary $40, tier 3 non-formulary $60, tier 4 self-administered injectable drugs 30%, per prescription up to a 34-day supply.	Not covered
c) Prescription Mail Service	Tier 1 generic formulary $30, tier 2 brand formulary $100, tier 3 non-formulary $150, tier 4 self-administered injectable drugs 30%, per prescription up to a 90-day supply. For the tier 4 self-administered injectable prescription drugs, the 34-day supply maximum coinsurance per prescription is $250 and $500 per 90-day supply. Includes coverage for smoking cessation prescription legend drugs when enrolled in an Anthem Blue Cross and Blue Shield approved smoking cessation counseling program, up to $250 per member per calendar year, $500 per lifetime. If a provider prescribes a drug for which an FDA-approved Class A generic substitute is available, the benefit will be limited to the cost of the generic substitute. All medically necessary "dispense as written" and "no substitution" prescriptions do not allow a generic substitution and require prior authorization from Anthem Blue Cross and Blue Shield. If a brand name drug is used when a generic equivalent is available, you pay the brand formulary copayment or nonformulary copayment plus the retail cost difference between the brand name drug and generic substitution. For drugs on our approved list, contact Customer Service at 1-800-843-5621 or 303-831-2384. Prescription drugs will be covered only when received from a participating pharmacy.	Not covered

	IN-NETWORK	OUT-OF-NETWORK
12. INPATIENT HOSPITAL	80% after deductible	60% after deductible
13. OUTPATIENT/AMBULATORY SURGERY	80% after deductible	60% after deductible
14. LABORATORY AND X-RAY	80% after deductible	60% after deductible
15. EMERGENCY CARE[3]	80% after deductible	60% after deductible
16. AMBULANCE	80% after deductible (limited to $350 per trip for ground ambulance and $2,500 per trip for air ambulance)	60% after deductible (limited to $350 per trip for ground ambulance and $2,500 per trip for air ambulance)
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	80% after deductible	60% after deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS[4] **CARE**	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
19. 0THER MENTAL HEALTH CARE		
a) Inpatient care	80% after deductible (limited to 45 full or 90 partial days per member per calendar year combined with out-of-network)	60% after deductible (limited to 45 full or 90 partial days per member per calendar year combined with in-network)
b) Outpatient care	80% after deductible (limited to 30 visits per member per calendar year combined with out-of-network and line 20 outpatient alcohol and substance abuse, with no less than $1,000 in benefits for mental health care)	60% after deductible (limited to 30 visits per member per calendar year combined with in-network and line 20 outpatient alcohol and substance abuse, with no less than $1,000 in benefits for mental health care)
20. ALCOHOL & SUBSTANCE ABUSE		
a) Inpatient care	80% after deductible limited to medically necessary care	60% after deductible limited to medically necessary care
b) Outpatient care	80% after deductible (limited to 30 visits per member per calendar year combined with out-of-network and line 19 outpatient mental health care, with no less than $500 in benefits for alcohol abuse and no less than $250 in benefits for substance abuse)	60% after deductible (limited to 30 visits per member per calendar year combined with in-network and line 19 outpatient mental health care, with no less than $500 in benefits for alcohol abuse and no less than $250 in benefits for substance abuse)
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY	80% after deductible	60% after deductible
22. DURABLE MEDICAL EQUIPMENT	80% after deductible	60% after deductible
23. OXYGEN	80% after deductible	60% after deductible
24. ORGAN TRANSPLANTS	80% after deductible	60% after deductible
25. HOME HEALTH CARE	80% after deductible (up to 60 visits per calendar year combined with out-of-network benefits)	60% after deductible (up to 60 visits per calendar year combined with in-network benefits)
26. HOSPICE CARE		
a) Inpatient	80% after deductible	60% after deductible
b) Outpatient	80% after deductible	60% after deductible
27. SKILLED NURSING FACILITY CARE	Not covered	Not covered

	IN-NETWORK	OUT-OF-NETWORK
28. DENTAL CARE	No dental benefits are available under this medical plan. However, the State of Colorado offers a separate dental plan for eligible employees and dependents. See enrollment materials.	
29. VISION CARE	Vision benefits included in this plan can be found on the separate Anthem Vision Summary Description.	
30. CHIROPRACTIC CARE	80% after deductible (limited to a maximum payment of $750 per calendar year combined with out-of-network)	60% after deductible (limited to a maximum payment of $750 per calendar year combined with in-network)
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	BlueCares for You disease management programs that include management for CAD, CHF, ESRD, maternity, asthma, diabetes, and a 24-hour nurse healthline. Hearing aids, exam and fitting not subject to deductible or coinsurance (limited to maximum payment of $500 every three years combined with out-of-network) Infertility treatment 80%, subject to deductible (limited to a maximum payment of $2,500 per calendar year combined with out-of-network) When a member desires another professional opinion, they may obtain a second surgical opinion subject to plan provisions.	BlueCares for You disease management programs that include management for CAD, CHF, ESRD, maternity, asthma, diabetes, and a 24-hour nurse healthline. Hearing aids, exam and fitting not subject to deductible or coinsurance (limited to maximum payment of $500 every three years combined with in-network) Infertility treatment 60%, subject to deductible (limited to a maximum payment of $2,500 per calendar year combined with in-network) When a member desires another professional opinion, they may obtain a second surgical opinion subject to plan provisions.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[5]	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable. Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy, a list of exclusions is available immediately upon request from your carrier or plan sponsor (e.g. employer). Review them to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	USING THE PLAN	
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	Yes

38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	**USING THE PLAN** No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield
39. What is the main customer service number?	303-831-2384 or 1-800-843-5621	
40. Whom do I write/call if I have a complaint or want to file a grievance?[6]	Anthem BCBS Complaints and Appeals 700 Broadway Denver, CO 80273 303-831-2384 or 1-800-843-5621	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850 Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form # 96744 Large group	

PART E: COST

43. What is the cost of this plan?	**Employee Portion**	**State Contribution**	**Full Premium**
Employee Only	$67.74	$156.06	$223.80
Employee + 1 Dependent	$211.80	$232.52	$444.32
Employee + 2/More Dependents	$294.30	$326.46	$620.76

PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION, AND PROFIT

Any person interested in applying for coverage, or who is covered by or who purchased coverage under this plan, may request answers to the questions listed below. The request may be made orally or in writing to the insurance company and shall be answered within five (5) working days of the receipt of the request.

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?
- What percentage of total Colorado premiums are spent on health-care expenses as distinct from administration and profit?

Endnotes:

1. "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

2. "Out of Pocket Maximum" The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.

3. "Emergency Care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life-or-limb threatening emergency existed

4. "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

5. Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

6. Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

ANTHEM VISION SUMMARY OF BENEFITS

This Summary Plan Description outlines the vision benefits available to you through the Anthem Vision Plan. This is a summary of your vision benefit. Please review your benefit certificate for plan details. For eligibility definitions please contact your group administrator.

Anthem Vision's Provider Network: **Anthem Vision** contracts with many providers which includes independent optometrists and ophthalmologists as well as retail locations. Anthem members have access to approximately 10,000 conveniently located providers nationwide. Members may call Anthem Vision toll-free (800) 231-2583 or visit www.anthem.com any time for provider locations. Schedule an appointment with your Anthem provider; identify yourself as an Anthem vision member for fast, paperless determination and confirmation of benefits.

Network Provider: Maximum benefits are achieved when members access their benefits from an ***Anthem*** Participating Vision Provider. Copayment(s) may apply to in-network benefits.

Non-Network Vision Provider Reimbursements: Members may go to a non-participating (non-network) vision provider and pay the provider directly for their examination. Members may then submit an original itemized invoice along with the Member's I.D. number to ***Anthem Vision*** for reimbursement according to the Non-Par Reimbursement schedule identified in this Summary of Benefits.

Materials: Anthem *Providers* agree to Preferred Pricing that is significantly below retail. Members are able to achieve substantial savings on frames, lenses or contact lenses, lens treatments, specialized lenses and various sundry items. Members may save approximately 20% to 40% or more off retail when they visit an ***Anthem*** Provider.

Copayment(s): Copayment amounts are applicable to Network Vision Provider examinations.

Anthem Vision Benefits	**Member Benefit from Network Provider**	**Non-Par Reimbursement****
Vision Examination*:* Each member is entitled to a comprehensive vision examination by an Anthem Vision Provider. This is a vision examination only and does not cover a separate contact lens professional fitting fee. ***Availability*** **: Once every 12 months***	**Copayment $20**	**Up to reimbursement of $35**
Materials: Prescription lenses and frames	**Available at Anthem Vision Preferred Prices**	**Not covered**
Contact lenses:	**Available at Anthem Vision Preferred Prices**	**Not covered**

**** Benefit are available from the last date of service.***

Limitations and Exclusions:

This is a primary vision care benefit and is intended to cover only eye examination only. Materials and any items not covered may be purchased at Preferred Pricing from an Anthem Vision Provider. In addition, the examination is only payable while the Group and individual Member coverage is in force.

- Orthoptics or vision training and any supplemental testing.
- Medical or surgical treatment of the eyes.
- An eye exam or corrective eyewear required by an employer as a condition of employment.
- Any injury or illness covered under Workers' Compensation or similar law, or which is work related.
- Sub-normal vision aids.
- Experimental or non-conventional treatments or devices.
- Safety eyewear.

Welcome

Welcome to Anthem Blue Cross and Blue Shield, where our mission is to improve the health of the people we serve. You have enrolled in a quality health benefit program that pays for many of your health care expenses, including most expenses for physician and outpatient care, emergency care and hospital inpatient care.

This certificate is a guide to your coverage. Please review this document, as well as any enclosures, so you are familiar with your benefits, including their limitations and exclusions. Then keep this certificate in a convenient place for quick reference. By learning how your coverage works, you can help make the best use of your health care coverage.

For questions about your coverage, please call our customer service department between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday, or visit our website. The local and toll-free customer service numbers and our website address are conveniently printed at the bottom of every page of this certificate. For the on-line provider directory visit the web site at www.medicalquest/costate.com.

Thank you for selecting Anthem Blue Cross and Blue Shield for your health care coverage. We wish you good health.

Caroline Matthews
Chief Operating Officer
Anthem Blue Cross and Blue Shield

Acceptance of coverage under this certificate constitutes acceptance of its terms, conditions, limitations and exclusions. Members are bound by all of the terms of this certificate.

Your health benefit coverage is defined in the following documents:

- This certificate, the *Health Plan Description Form* and any amendments or endorsements thereto.
- The Benefit Enrollment/Membership Change Form for the subscriber and the subscriber's dependents.
- The health benefit ID card.

In addition, the employer has the following important documents that are part of the terms of the health benefit coverage:

- The Employer Master Contract between Anthem and the employer.

Anthem, or anyone acting on our behalf, will generally determine how benefits will be administered and who is eligible for participation in a manner that is consistent with the terms of this certificate. In the event of any question as to the interpretation of any provision of this certificate, Anthem's determination will be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are medically necessary, experimental/investigative, or, in the case of surgery, cosmetic. However, a member may utilize all applicable complaint, grievance and appeal procedures available under this certificate.

This certificate is not a Medicare Supplement policy. If you are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from Anthem.

Table of Contents

Part 1: Medical Plan

Part 2: Vision Plan

Member Rights and Responsibilities

As a member, you have the right to:

- Receive information regarding terms and conditions of your health care benefits.
- Be treated respectfully and with consideration.
- Receive all the benefits to which you are entitled under your certificate.
- Obtain complete information from a provider regarding your diagnosis, treatment and prognosis, in terms you can reasonably understand.
- Receive quality health care through providers in a timely manner and in a medically appropriate setting.
- Have a candid discussion, with providers, of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Participate with your physician(s) in decision-making about your health care treatment.
- Refuse treatment and be informed by your physician(s) of the medical consequences.
- Receive wellness information to help you maintain a healthy lifestyle.
- Express concerns and complaints to Anthem about the care and services provided by physicians and other providers, and to have Anthem investigate and take appropriate action.
- File a complaint or appeal a decision with Anthem as outlined in the **COMPLAINTS, APPEALS AND GRIEVANCES** section and contact the Division of Insurance about a concern without fear of reprisal.
- Expect that your personal health information will be maintained in a confidential manner.
- Make recommendations regarding Anthem's member rights and responsibilities policies.

As a member, you have the responsibility to:

- Use providers who will provide or coordinate your total health care needs, and to maintain an ongoing patient-physician relationship.
- Provide complete and honest information about your health care status and history.
- Follow the treatment plan recommended by your providers.
- Understand how to access care in non-emergency and emergency situations, and know your health care benefits as they relate to out-of-network coverage and copayments.
- Notify the provider or Anthem about concerns you have regarding the services or medical care you receive.
- Be considerate of the rights of other members, providers and Anthem's staff.
- Read and understand your certificate and the *Health Plan Description Form.*
- Pay all member payment requirements in a timely manner.
- Provide Anthem with complete and accurate information about other health care coverage and/or benefits you may carry.
- Participate in understanding your health problems and developing mutually agreed upon treatment goals with your provider.

About Your Health Coverage

This is a Preferred Provider Organization (PPO) health insurance coverage, which means members have in-network (PPO) and out-of-network (non-PPO) benefits. In-network benefits are services provided to members by providers who are participants in the Anthem network as described under the heading "PPO Providers" in this section. Out-of-network benefits are those provided to members by providers who are not participants in the Anthem network.

This PPO coverage offers great flexibility because members may choose how to use their benefits and to control their out-of-pocket expenses. When members use their PPO in-network benefits, they receive the highest level of benefits at the lowest cost. The *Health Plan Description Form* lists payment levels for both in and out-of network care.

Providers

PPO Providers

Providers who have entered into a network agreement with Anthem are PPO providers. Services provided by a PPO provider are considered in-network. When members visit a PPO provider they have lower out-of-pocket expenses. A PPO provider will bill Anthem directly and accept Anthem's maximum benefit allowance as payment in full. The maximum benefit allowance is the dollar amount approved by Anthem for a specific covered service. The PPO provider will also coordinate the member's care. Member in-network cost sharing responsibilities to PPO providers can be found on the *Health Plan Description Form* under the heading "In Network." Members are responsible for determining if their provider is a PPO provider. Members may visit our website or call our customer service department for provider information.

Anthem makes no guarantee that a PPO provider will be available for all services and supplies covered under the member's PPO coverage. For a limited number of services and supplies, Anthem does not have arrangements with PPO providers. The counties in which Anthem does not have PPO providers for such services and supplies can be obtained by calling our customer service department. If Anthem does not have a PPO provider for a covered service and Anthem does not inform the member of an alternative for obtaining the service from a non-PPO or non-participating provider, the member may seek service from a non-PPO or non-participating provider, and the member will pay no more than what the member would have paid for such covered service if it had been received from a PPO provider. However, in some circumstances Anthem may require the member to travel a reasonable distance for care within our provider network to receive services from a PPO or participating provider. Under these circumstances, if the member knowingly chooses to obtain the service from a non-participating provider rather than the PPO or participating provider, the member will be responsible for paying any charges from the non-participating provider that exceed the maximum benefit allowance paid by Anthem to the provider. Anthem will not deny or restrict PPO covered services solely because the member obtains treatment from a non-PPO provider or non-participating provider; however, the member may have a higher financial responsibility.

Non-PPO Providers

Non-PPO providers are those who have not entered into a network agreement with Anthem. Services provided by a non-PPO provider are considered out-of-network. When members visit a non-PPO provider they may have higher out-of-pocket expenses. Members' out-of-network cost sharing responsibilities to non-PPO providers can be found on the *Health Plan Description Form* under the heading "Out-of-Network." Two types of non-PPO providers exist:

Participating Providers - Non-PPO providers who have entered into a participating agreement with Anthem to bill Anthem directly for covered benefits are participating providers. The participating agreement differs from the network agreement that PPO provider's sign. Although Anthem has contracted with participating providers, they are non-PPO providers. Participating providers agree to accept our maximum benefit allowance as payment in full.

Non-Participating Providers - Providers who have not signed agreements with Anthem are non-participating providers. Members may be obligated to pay more out-of-pocket expenses when they visit a non-participating provider. Non-participating providers do not have to accept our maximum benefit allowance as payment in full. They may bill members directly for any amount over Anthem's maximum benefit allowance for a covered service. Members must pay any difference between Anthem's maximum benefit allowance and the non-participating provider's billed charges.

Anthem will pay a non-participating provider's reimbursement amounts directly to the member. Anthem is not required to honor an assignment of benefits to non-participating providers. Anthem may honor an assignment of benefits to non-participating providers at our sole discretion. If Anthem pays the member directly, the member will be responsible for paying the non-participating provider of services for all charges. These payments fulfill our obligation to the member for these services.

Cost Sharing Requirements

Cost sharing refers to how Anthem and its members share the cost of health care services. It describes what Anthem is responsible for paying and what the member is responsible for paying. Members meet their cost sharing requirements through the payment of deductibles, and coinsurance (as described below) . Cost sharing requirements depend upon the choices the member makes in accessing services. For example, if the member chooses to use a PPO provider or PPO facility, the member's out-of-pocket expenses may be less than if the member chooses a non-PPO provider or facility.

Anthem has worked with physicians, hospitals, pharmacies and other health care providers to control health care costs. As part of this effort, many providers agree to control costs by giving discounts to Anthem. Most other insurers maintain similar arrangements with providers.

In their contracts, PPO providers and non-PPO participating providers agree to accept Anthem's maximum benefit allowance as payment in full for covered services. Anthem determines a maximum benefit allowance for all procedures performed by providers. For example, the hospital may charge $12,000 for a procedure (its billed charge) and Anthem's maximum benefit allowance for that procedure is $8,000. The deductible, copayment and coinsurance are based on the maximum benefit allowance of $8,000, not the hospital's billed charge of $12,000. In this example, the member's out-of-pocket costs would be lower if the member uses a participating provider.

In addition to accepting Anthem's maximum benefit allowance, many participating providers also give Anthem additional discounts. These additional discounts help control health care costs and benefit members. The discounts allow Anthem or employers to offer more extensive benefit coverages with lower deductibles, copayments and coinsurance amounts. These discounts are taken into account in a variety of ways in determining the amount members pay for health care.

Using the example described above, if the participating hospital charges $12,000 for a procedure and the maximum benefit allowance is $8,000, any additional discounts are deducted, the deductible, copayment and coinsurance are then subtracted and the balance is paid by Anthem, on behalf of the employer. **If a member does not use a participating provider, any amount over the maximum benefit allowance is the member's responsibility (unless Anthem does not have a participating provider to provide the service, as explained above).**

Discounts allow Anthem or employers to offer more extensive coverages with lower deductibles, copayments and coinsurance amounts and make it possible for Anthem to offer a lower-cost benefit coverage to members or their employers. Without provider discounts, employers might have to choose a less extensive coverage that offers fewer benefits or pass the additional costs on to employees, thus increasing the cost of health care coverage to members.

The contracts between Anthem and its providers include a "hold harmless" clause which provide that a member cannot be liable to the provider for moneys owed by Anthem for health care services covered under this certificate.

Copayment

Copayments are required for prescription drugs. A copayment is a predetermined, fixed-dollar amount a member must pay to receive a specific service. Members are required to pay a copayment to participating pharmacies for covered prescription drugs as listed in the *Health Plan Description Form*. Members are responsible for making copayments directly to the participating pharmacy. Members must pay copayment amounts even after meeting deductible and/or coinsurance requirements. Copayment amounts do not apply to deductible and/or coinsurance requirements.

Deductible

A deductible is a specified amount of expense for covered services that the member must pay within each member's benefit year before Anthem provides benefits. The deductible amount is listed on the *Health Plan Description Form*.

There are two separate deductibles: one for in-network PPO providers and one for out-of-network providers. Charges from a non-PPO provider cannot be applied toward meeting the PPO deductible, and charges from a PPO provider cannot be applied toward meeting the non-PPO deductible. A new deductible is required for each member's benefit year. The non-PPO deductible applies if Anthem has a PPO provider to provide a covered service or supply and the member receives the service or supply from a non-PPO provider. Some services are not subject to deductible and listed on the *Health Plan Description Form*.

Family Deductible - Under a family membership, when the family members collectively meet the family deductible, then all family members are eligible for benefits.

Coinsurance

Members must first meet their required deductible. After the deductible is met in each member's benefit year, Anthem pays a percentage of charges for covered services as listed on the *Health Plan Description Form*. This percentage is called coinsurance.

Members pay coinsurance for covered services until the out-of-pocket annual maximum is reached for the member's benefit year. Until the out-of-pocket maximum is reached, Anthem pays the remaining percentage. Once the out-of-pocket annual maximum is reached, Anthem pays 100 percent of any remaining eligible charges for the remainder of the member's benefit year.

Family Coinsurance - Under a family membership, when the family members collectively meet the family coinsurance, then all family members are eligible for benefits. Maximum Benefit Allowance

Reimbursement for benefits paid under this coverage (except for out-of-network emergency care by a non-participating provider) is limited to the maximum benefit allowance. The maximum benefit allowance is the dollar amount determined and approved by Anthem for covered services and procedures. Members' applicable cost sharing requirements are based on the maximum benefit allowance, not on a physician's billed charges. PPO and non-PPO participating providers have signed agreements to accept the maximum benefit allowance as payment in full.

Maximum Lifetime Benefits

Under this benefit design, a maximum lifetime payment is unlimited.

Managed Care Features

Managed care is a system of health care delivery with the goal to give members access to quality, cost effective health care while optimizing utilization and cost of services, and measuring provider and coverage performance. Anthem uses a variety of administrative processes and tools, such as preauthorization for health care services, care management, concurrent hospital review and disease management, to help determine the most appropriate use of the health care services available to our members. This section of the certificate explains how these managed care features are used and guide's members through the necessary steps to take to obtain care. Additional information on how a member should proceed in case of an emergency can be found in the **MEMBER BENEFITS** section.

This certificate does not restrict or interfere with the right of any member entitled to service and care in a hospital to select a hospital or to choose an attending physician. Anthem requires that physicians hold a valid physician's license, practice within the scope of that license and be a member of, or acceptable to, the attending staff and board of directors of the hospital in which the services are to be provided.

Benefits provided under this coverage do not regulate the amounts charged by providers of medical care.

Anthem's Process to Determine Whether Services are Covered

To determine whether a health care service is a covered benefit, Anthem considers whether the service is medically necessary and whether the service is experimental/investigational or cosmetic and is otherwise not excluded under this coverage. Anthem uses numerous resources, including current peer-reviewed medical literature, Anthem's adopted medical policies and practice guidelines, guidelines obtained from recognized national organizations and professional associations and consultations with physician specialists whether a particular service is covered. Anthem will assist the member by determining what services are covered under the member's chosen coverage and what services are excluded from the health coverage.

Medically Necessary Health Care Services - Anthem determines whether services, procedures, supplies or visits are medically necessary. Only medically necessary services, procedures, supplies or visits are covered by the member's coverage. Anthem uses medical policy, medical practice guidelines, professional standards and outside medical peer review to determine medical necessity. Anthem's medical policy reflects current standards of practice and evaluates medical equipment, treatment and interventions according to an evidence-based review of scientific literature. Medical technology is constantly changing, and Anthem reserves the right to periodically review and update medical policies. Providers and members may go to our website to view a list of services that are considered medically necessary. The benefits, exclusions and limitations of a member's coverage take precedence over medical policy. Certain procedures, diagnostic tests, durable medical equipment, home health, home IV services and medications require preauthorization. The current list of the items can be found on Anthem's web site. If a member uses a PPO or participating provider, it is the provider's responsibility to preauthorize the test, equipment, service or procedure. If a member uses a non-participating provider, the member may be held responsible for the expense of the test, equipment, service or procedure.

Experimental/Investigational and/or Cosmetic Procedures - Anthem will not pay for any services, procedures, surgeries or supplies that it considers experimental/investigational and/or cosmetic. Providers and members may go to Anthem's website and select "Physicians and Providers/Colorado/Anthem Medical Policies" to view services, procedures, surgeries and supplies that Anthem considers experimental/investigational and/or cosmetic

Appropriate Place and Preauthorization

Health care services may be provided in an inpatient or outpatient setting, depending on the severity of the medical condition and the services necessary to manage the condition in a given circumstance. Anthem covers care received in both environments provided the care received is appropriate to the setting and is medically necessary. Inpatient settings include hospitals. Outpatient settings include physicians' offices and ambulatory surgery centers.

Preauthorization is a process Anthem uses to ensure a member's care is provided in the most medically appropriate setting. The preauthorization process may set limits on the care to be given. Preauthorization is required prior to an admission to a hospital or before receiving certain procedures or services. Some drugs also require preauthorization.

The PPO or participating provider who schedules an admission or orders the procedure or service is responsible for obtaining preauthorization. To determine which services and/or drugs require preauthorization, and/or to be sure that preauthorization has been obtained, the member may contact Anthem. Our customer service department telephone number and website address are located on the bottom of each page of this certificate.

Inpatient Admissions - Inpatient admissions require preauthorization and concurrent review for all inpatient stays. The member's health care provider must call the number for **Provider Authorization** on the member's health benefit ID card to request preauthorization. Anthem will review the request for preauthorization. If the inpatient stay is approved, all benefits available under the member's coverage are provided. More information can be found in the **MEMBER BENEFITS** section. Anthem initially authorizes a specified number of days for the inpatient stay and reevaluates such authorization if additional days are requested by the health care provider. This process facilitates timely discharge or transfer of the member to the appropriate level of care.

If Anthem does **not** grant preauthorization, the member will be held financially responsible for all inpatient stay charges. The member or the member's representative may appeal our preauthorization decision by following the procedure outlined in the **COMPLAINTS, APPEALS AND GRIEVANCES** section of this certificate.

Scheduled Admissions - The member's health care provider must obtain preauthorization prior to the admission from Anthem for all scheduled inpatient admissions as well as concurrent reviews for continued stays past the number of days authorized. Preauthorization must be requested from Anthem at least seven days prior

to admission. Anthem will send written confirmation of Anthem's decision to the member and the health care provider within two business days of receipt of all necessary information.

Unscheduled (Emergency) Admissions - Anthem requires notification of an unscheduled (emergency) admission within one business day after the admission. The member is responsible for ensuring that Anthem has been notified of the unscheduled admission unless the member is unable to do so. Examples of unscheduled or emergency admissions include admissions involving accidents or onset of labor in pregnancy. Failure to notify Anthem may result in a reduction or denial of coverage.

Inpatient admissions include acute care facilities (hospitals), rehabilitation facilities, long-term care acute facilities, sub acute facilities, rehabilitation facilities, and inpatient hospice.

Outpatient Procedures- Many procedures on an outpatient basis must be preauthorized. The member's health care provider must contact Anthem for preauthorization. Members may go to Anthem's website or call Anthem's customer service department for a list of outpatient procedures and services that require preauthorization. These services may be performed in a hospital on an outpatient basis or in a freestanding facility, such as an ambulatory surgery center.

Upon receipt of a preauthorization request, Anthem may require additional information to determine medical necessity. Anthem will send written confirmation of Anthem's decision to the member and the health care provider within two business days of Anthem's receipt of all necessary information. The preauthorization will be valid only for a specific period of time and place. The member must obtain the requested service within the time allotted in the preauthorization and at the place authorized. If the preauthorization period expires, or if additional services are requested, the provider must contact Anthem to request another authorization.

A preauthorization that a service requested meets medical necessity criteria **does not guarantee** that payment will be allowed. Fraud or abuse could cause a denial of payment. When Anthem receives the member's claim(s), Anthem will review them against the terms of this certificate.

The member or the member's representative may appeal our preauthorization decision by following the procedure outlined in the **COMPLAINTS, APPEALS AND GRIEVANCES** section.

Appropriate Length of Stay

Anthem, in conjunction with the member's providers, determines the appropriate length of an inpatient hospital stay for which benefits will be paid for members by using medical policies and medical care guidelines, such as inpatient and surgical care optimal recovery guidelines. With the use of these guidelines and by encouraging member education, the member is more likely to receive the appropriate level of care and achieve favorable outcomes.

Concurrent Review - While a member is in the hospital, the member's medical care will be reviewed to determine whether the member is receiving appropriate and medically necessary hospital services. If the member has an unscheduled admission to the hospital for any reason, including a medical emergency, maternity care, alcoholism detoxification, or substance abuse care, Anthem **requires** notification within one business day of the admission to assist with management of the hospital benefits and planning for covered medical services during hospitalization and after discharge.

At some point during hospitalization, Anthem may determine that further hospitalization is not medically necessary. Anthem will advise the attending physician and the hospital of this determination. The hospital will give the member timely notice of such a determination. If a member elects to remain in the hospital after the member has been notified that continued hospitalization is not medically necessary, Anthem will not pay for services after the recommended date of discharge. Anthem will also send written notification of the decision to the member, the attending physician and the hospital. **The member will be responsible for all charges incurred after the recommended day of discharge.**

If a member or provider disagrees with a concurrent hospital review decision, the member may appeal by following the procedure outlined in the **COMPLAINTS, APPEALS AND GRIEVANCES** section.

Retrospective Claim Review - Retrospective review of claims consists of reviewing services after the services have been provided to determine whether the services were provided as preauthorized, to evaluate claim charges and to review appropriateness of services billed based on available benefits, medical policy and medical necessity. Anthem may request and review medical records to assist in payment decisions. If it is determined that benefits are not available, Anthem will not pay.

Ongoing Care Needs

Ongoing care is coordinated through services such as utilization management, care management and disease management.

Utilization Management - Utilization management is used to determine if a service is medically necessary, delivered in the right setting and for the appropriate length of time. Care is compared to nationally recognized guidelines. This review may be used to determine payment for covered services. However, the decision for treatment is solely between the member and provider regardless of Anthem's decision made regarding reimbursement.

Care Management - Care management is used when illnesses or injuries are so complex that individualized coordination of care is helpful. Examples of such situations include the medical management of a transplant candidate or of a patient with a spinal cord injury. In either of these cases, a care manager may work with the member and/or the member's family to help coordinate and facilitate the administration of medical care. A care manager may also help organize a safe transition from hospital to home care. The care management program is designed to identify patients as early as possible in their course of medical treatment who may benefit from care management and to see that issues pertinent to the case are assessed and addressed, documented, and resolved in a consistent and timely manner. Care management promotes quality outcomes.

Depending on the level of care management the member may need, a care manager may be assigned to the member. Anthem employs nurses and other medically trained staff with special training in the coordination of care in complex cases. The member may or may not have direct contact with an Anthem care manager. This depends on the availability of a liaison at the facility where the member is admitted. If a care manager is assigned, the care manager's telephone number is provided to the member so that the member may contact the care manager with any questions. An assigned care manager works with the providers, the member and/or the member's family to create a plan of care, implement that plan, monitor the use and effectiveness of services, and determine if the member is receiving services in a timely manner and in the most appropriate setting. Anthem has discretion as to which members it offers care management. Anthem may not offer care management to all members of an employer group or to all members with similar conditions.

Anthem's care management program is tailored to the individual. In certain extraordinary circumstances involving intensive care management, Anthem may, at its sole discretion, provide benefits for alternate care that are not listed as covered services. Anthem may also extend covered services beyond the contractual benefit limits of this coverage. Anthem will make these decisions on a case-by-case basis. A decision to provide extended benefits or approve alternate care in one case does not obligate Anthem to provide the same benefits again to that member or to any other member. Anthem reserves the right, at any time, to alter or cease providing extended benefits or approving alternate care. In such cases, Anthem will notify the member or the member's representative in writing.

Disease Management - Disease management is used to help coordinate care for members who have been diagnosed with specific, persistent or chronic conditions. Anthem may offer disease management programs to members with high-risk pregnancies or who have been diagnosed with chronic illnesses, such as diabetes, heart disease and asthma.

Disease management strategy includes working with the member to promote self-management and encouraging compliance with the plan of care developed by the member's provider. Disease management emphasizes disease prevention, member education and coordination of care to avoid acute episodes and/or gradual worsening of the disease over time. Anthem's disease management programs are based on the best evidence and practices available in peer-reviewed medical literature. Reports are regularly communicated to the member's provider to promote continuity of care.

Anthem may not offer disease management programs to all members who have conditions such as those mentioned above, even if they are in the same employer group. A decision to offer a disease management program to a member does not obligate Anthem to offer other programs to that member or to offer that program to other members.

Participation in disease management programs is voluntary, and members may choose whether to participate at any time. More complicated conditions may require more intense and/or frequent services.

The PPO or participating provider agreement of providing covered services may include financial incentives or risk sharing relationships related to the provision of services or referral to other providers, including network providers

and disease management programs. Members may contact the provider or Anthem for questions regarding such incentives or risk sharing relationships.

Participation in Ongoing Needs Programs - There are several ways for eligible members to become involved in an Anthem care management or disease management program. Anthem can identify members that Anthem believes may benefit from the programs, or physicians may refer their Anthem patients to us. Members may also contact Anthem directly by calling Anthem's "Help Line" at (303) 764-7066 or (877) 225-2583. Additional information about Anthem's disease management and wellness programs is available on Anthem's website under the **Blue*Cares* for You** heading.

Membership

Subscriber

The subscriber is the member in whose name the membership is established.

An eligible employee is a person employed by the State of Colorado who meets the definition of Employee as defined by Colorado Revised Statues (CRS) 24-50-601 through 615. Temporary workers are not eligible.

Dependents

The employer establishes the requirements for determination of dependent status for all dependents except for a disabled dependent child, for whom eligibility is determined by Anthem. Proof of dependent eligibility must be submitted to the employer within the time period established by the employer. A member may obtain any required form from the payroll/personnel administrator. A subscriber's dependents may include the following:

- **Legal spouse.**
- **Common-law spouse.**
- **Newborn child**. A newborn child born to the subscriber or subscriber's spouse is covered under the subscriber's coverage for the first 31 days after birth. If the mother of the newborn child is a dependent child of the subscriber, the newborn is **not** covered (see the heading **Grandchild** in this section).

  During the first 31 day-period after birth, coverage for a newborn child shall consist of medically necessary care for injury and sickness, including care and treatment of medically diagnosed congenital defects and birth abnormalities, without regard to the limitations and exclusions applicable to other conditions or procedures covered by Anthem. All services provided during the first 31 days of coverage are subject to the cost sharing requirements and the maximum lifetime benefit that are applicable to other sicknesses, diseases and conditions otherwise covered.
- **Adopted child.** An unmarried child (who has not attained 18 years of age) adopted while the subscriber or the subscriber's spouse is eligible for coverage will be covered for 31 days after the date of placement for adoption.

  "Placement for adoption" means circumstances under which a subscriber assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement terminates when the legal obligation for support terminates.
- **Dependent child**. An unmarried child (including a stepchild or a disabled child) under 19 years of age can be covered under the terms of this certificate. The child is automatically removed from coverage as a dependent at the end of year in which they turn age 19 unless they qualify as an **overage dependent child**. If the subscriber or the subscriber's spouse is subject to a qualified medical child support order for a dependent child of the subscriber or the subscriber's spouse, the dependent child is eligible for coverage, whether the child lives with the subscriber or the subscriber's spouse.
- **Overage dependent child.** An unmarried child under 24 years of age who is financially dependent on the parent can be covered under the terms of this certificate. The child is automatically removed from the coverage as a dependent at the end of the month in which they turn age 24. A dependent child who is no longer eligible for coverage may be eligible for continuation coverage. Information can be found under the heading C*ontinuation of Coverage* in this section.
- **Disabled dependent child.** An unmarried child who is 19 years of age or older, medically certified as disabled, and dependent on the parent can be covered under the terms of this certificate. Anthem must receive notice of the disability for the disabled dependent to continue coverage. A completed Mentally or Physically Disabled Dependent Form must be submitted for the disabled dependent to be eligible for coverage. Completion of the Mentally or Physically Disabled Dependent Form does not guarantee continued coverage unless such request is approved by Anthem. The subscriber and the disabled dependent's physician must complete this form and submit it to the payroll/personnel administrator. A member may obtain a Mentally or Physically Disabled Dependent Form from the payroll/personnel administrator.
- **Grandchild.** A grandchild of a subscriber or a subscriber's spouse is not eligible for coverage unless the employer receives and approves an affidavit with the required information, which is signed by the subscriber and notarized. Contact the employer for the required affidavit and eligibility requirements.

Medicare-Eligible Members

Before a member becomes age 65, or if a member qualifies for Medicare benefits through other circumstances, the member is responsible for contacting the local Social Security Administration office to establish Medicare eligibility. The member should then contact the member's employer to discuss coverage options.

If a member qualifies under the provisions of federal law for the working aged, then the member age 65 and older and/or the member's spouse age 65 or older may continue coverage under this health care coverage. If a working aged eligible Medicare beneficiary enrolls with Medicare and requests Medicare as primary coverage, coverage under this certificate ends for that member. If a member qualifies under the provisions of federal law for the working aged and the employer has less than 20 employees (including full-time and part-time employees), the member age 65 or older and/or the member's spouse age 65 or older must enroll in Medicare Part A and/or Part B and coverage under this coverage will continue, but the benefits will be coordinated with Medicare, with coverage under this coverage secondary to any Medicare coverage. Special Medicare Secondary Payer (MSP) rules apply if a member is receiving benefits from Medicare due to a disability or end-stage renal disease. The member must contact the employer for more information and for eligibility guidelines that apply.

Enrollment Process

In order for eligible subscribers and their eligible dependents to obtain coverage, the subscriber must follow State of Colorado's enrollment process, which details who is eligible for enrollment and what forms are required for enrollment. Coverage under this certificate begins as of the effective date stated on the health benefit ID card. No services received prior to that date are covered.

Note: Submission of an Benefit Enrollment/Membership Change Form does not guarantee member enrollment.

Enrollment Forms

The subscriber must submit an Benefit Enrollment/Membership Change Form to add any dependents as members. Additional forms may be required for special dependent status. Subscribers may obtain an Benefit Enrollment/Membership Change Form or any additional forms from the payroll/personnel administrator.

Initial Enrollment

Eligible employees may apply for coverage for themselves and their eligible dependents by submitting an Benefit Enrollment/Membership Change Form. The payroll/personnel administrator must receive the Benefit Enrollment /Membership Change Form within 31 days after the date of hire or within 31 days of the expiration of the waiting period, as defined in the employer's new hire policy. The effective date of coverage will be the first of the month following the employee's date of hire.

If a member terminates health insurance coverage with Anthem, and within the same member's benefit year enrolls in a like-benefit coverage with Anthem, all covered benefits that have a benefit maximum will be carried into the new coverage. For example, if a benefit has a limit of one visit per member's benefit year and the member received that benefit under the prior coverage, that member is not eligible under the new coverage for the same benefit, as benefits have been exhausted for that member's benefit year.

Open Enrollment

An open enrollment period will be held annually or at other times as mutually agreed upon by the employer and Anthem. During the open enrollment period, an eligible employee and eligible dependents may enroll as members. The employer will notify the employee of an open enrollment. Anyone who enrolls during an open enrollment and has the applicable payroll deduction will have an effective date of January 1 of the upcoming year.

Newly Eligible Dependent Enrollment

A current subscriber of this coverage may add a dependent that becomes newly eligible due to a qualifying event. Qualifying events include marriage, birth, and placement for adoption or issuance of a court order. The payroll/personnel administrator must receive an Benefit Enrollment/Membership Change Form for the addition of the dependent within 31 days after the date of the qualifying event. Proof of the qualifying event, e.g. a copy of the marriage certificate or court order, must be attached to the completed Benefit Enrollment/Membership Change Form. Coverage will be effective on the date of the qualifying event.

When the subscriber or the subscriber's spouse is required by a court or administrative order for child support, to provide coverage for an eligible dependent, the eligible dependent must be enrolled within 31 days of the issuance of such order. The payroll/personnel administrator must receive a copy of the court or administrative order with the Benefit Enrollment/Membership Change Form. If the subscriber does not enroll the eligible dependent within 31 days of issuance of the order, the subscriber may enroll subject to the provisions described in this section under the heading **Special Enrollment for Eligible Employees and Eligible Dependents** and **Open Enrollment** in this section.

Special Enrollment for Eligible Employees and Eligible Dependents

Special enrollment is available for eligible employees and their eligible dependents that currently are not enrolled in the employer health coverage with Anthem. There are two events when special enrollment may occur, family status change and involuntary loss of coverage.

Family Status Change - Any eligible employee and eligible dependents may enroll when a family status change occurs. Qualifying events for special enrollment due to a family status change include marriage, divorce, birth, placement for adoption or the issuance of a qualified medical child support order. Coverage with Anthem will be effective on the date of the qualifying event. When the qualifying event is a birth, any charges related to labor and delivery due to the birth are not covered. The payroll/personnel administrator must receive the completed Benefit Enrollment/Membership Change Form within 31 days after the date of the qualifying event. Proof of the qualifying event, e.g., copy of marriage certificate or court order, must be attached to the completed Benefit Enrollment/Membership Change Form.

Involuntary Loss of Coverage - The involuntary loss of other group health insurance coverage is also a qualifying event for special enrollment for the eligible employee and/or eligible dependents. The involuntary loss of the other coverage must be due to termination of employment, reduction in the number of hours of employment, involuntary termination of creditable coverage, death of a spouse, legal separation or divorce, or termination of employer contributions toward the coverage. The payroll/personnel administrator must receive the completed Benefit Enrollment/Membership Change Form within 31 days after the date of the involuntary loss. If the employee is approved for special enrollment, the coverage with Anthem will be effective on the day following the loss of other coverage. If COBRA or state continuation coverage is available, enrollment may only be requested after exhausting the COBRA or state continuation coverage.

If the eligible employee and/or the eligible dependents had health insurance coverage elsewhere and voluntarily canceled such coverage, the eligible employee and/or the eligible dependents do not qualify for special enrollment. However, the eligible employee and/or the eligible dependents will be allowed to enroll at the employer's annual open enrollment.

Multiple Anthem Coverages

Members may have more than one group health insurance policy with Anthem or any of its affiliates. To be eligible for a premium refund, a member has 31days after the date duplicate coverage begins to notify Anthem if duplicate coverage is not desired. If notification is not received within this 31-day period, no retroactive refund in premium payments will be granted, but the member may still terminate the duplicate coverage.

How to Change Coverage

If a group provides members with multiple health care options, covered employees may switch coverage for themselves and their covered dependents to another coverage offered by the group during open enrollment.

Termination

Active Policy Termination

Member coverage ends on the first occurrence of one of the following events:

- On the date the Employer Master Contract between the group and Anthem is terminated.
- Upon the subscriber's death.
- When the required premium has not been paid.
- When the member has committed fraud or intentional misrepresentation of material fact.
- When the member is no longer eligible for coverage under the terms of the Employer Master Contract.

- When the member is deemed a "working aged," as defined by federal law, and Medicare becomes the member's primary coverage.
- When the subscriber's employer gives Anthem written notice that the subscriber is no longer eligible for coverage. Coverage will be terminated on the date of notification. Anthem reserves the right to recoup any benefit payments made for dates of service after the termination date.
- When Anthem receives a 31-day advance written notification to cancel coverage for any member. Coverage will end at the end of the month following the 31-day period. Anthem will credit membership premium paid in advance on behalf of canceled members, unless Anthem does not receive the cancellation request at least 31 days prior to the effective date of the cancellation.

Dependent Coverage Termination

To remove a dependent from coverage, the subscriber must complete an Benefit Enrollment/Membership Change Form within 31 days prior to the effective date of the change. If the change is received after the requested effective date, the change will be made effective the date Anthem is notified of the change. Anthem reserves the right to recoup any benefit payments made beyond the termination date.

Anthem will credit membership premium paid in advance on behalf of the terminated dependent unless Anthem does not receive the Benefit Enrollment/Membership Change Form within 31 days of the effective date of the change or if Anthem has paid any claims on behalf of the terminated dependent in the period for which the credit would otherwise be owed to the employer.

Coverage for a dependent ends on the last day of the month immediately preceding the next monthly premium due date following receipt of the request or on the first occurrence of one of the following events:

- When the subscriber notifies Anthem in writing to end coverage for a dependent.
- When the dependent child marries or no longer qualifies as a dependent by definition. Such a dependent has the right to select COBRA or state continuation coverage.
- On the date of a final divorce decree or legal separation for a dependent spouse. Such a dependent has the right to select COBRA or state continuation coverage**.**
- At the end of the month when legal custody of a child placed for adoption is terminated.

Certificate of Creditable Coverage

When a member's coverage with Anthem terminates, Anthem will send the subscriber a Certificate of Creditable Coverage, which will identify the length of the member's creditable coverage with Anthem. The member may need this letter as proof of prior coverage when the member enrolls with another coverage.

What Anthem Will Pay for After Termination

Except as provided below, Anthem will not pay for any services provided after the member's coverage ends even if preauthorization was received, unless eligibility was verified by the provider within two business days prior to each service received. Benefits cease on the date the member's coverage ends as described above. A member may be liable for benefit payments made by Anthem on behalf of the member for services provided after the member's coverage has terminated, even if the termination was retroactive.

When a member's coverage is terminated for any reason other than for nonpayment of premium, fraud or abuse, Anthem shall provide for continued care of the member being treated at an inpatient facility, until the member is discharged or transferred to another level of care, subject to the terms of this certificate. The discharge date is considered the first date on which the member is discharged from the facility or transferred to another level of care. When coverage has been terminated and a member receives additional facility care after the discharge date, Anthem will not cover additional services received.

Continuation of Coverage

Family and Medical Leave Act

When an employee takes time off from work pursuant to the Family and Medical Leave Act, health insurance coverage remains in force but the employee may be required to continue paying the employee's share of the premium. Members may contact their benefit coordinator for details.

State Continuation Eligibility and Notification

State Continuation Coverage Eligibility - Employees who do not qualify for COBRA eligibility may be eligible for state continuation coverage. The continuation coverage period will not exceed 18 months for the employee, and/or any dependents. To qualify, the member must have been covered by the employer's group health coverage for at least 6 consecutive months prior to any of the qualifying events described below.

State continuation coverage for employees and their dependents will commence on the date of the earliest of the following qualifying events:

- The employee's termination of employment for any reason
- The employee's reduction in working hours resulting in loss of coverage
- The employee's death
- Divorce or legal separation of the employee and spouse
- Loss of active dependent status under requirements of the coverage

State Continuation Coverage Notification - Unless termination or reduction in hours is the qualifying event, a subscriber, spouse or dependent child must notify the employer of eligibility to continue coverage within 30 days after becoming eligible. The employer is responsible for notifying the subscriber, spouse and/or dependent child of how to elect continuation coverage. Once notice has been given by the employer, Anthem must receive timely notice from the employer of a member's state continuation election. Anthem must also receive timely payment of appropriate premium charges for a member to be eligible for state continuation coverage.

Under state continuation coverage, Anthem must receive notice from the employer and the first premium payment from the member no later than 30 days after the qualifying event (except that if the employer fails to give timely notice to the subscriber of the subscriber's continuation rights, this deadline may be extended to 60 days after the qualifying event). For more details, the subscriber may contact the employer.

COBRA Eligibility and Notification

COBRA Eligibility - For employers with 20 or more employees, subscribers and their dependents who lose eligibility with a group are eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Members should contact the employer for additional information. COBRA coverage is available for 18, 29 or 36 months, depending on the qualifying event(s), and only if the application and premiums payment requirements of the federal law are met.

COBRA coverage is available to employees and their dependents for 18 months from the date of the following qualifying events:

- When an employee loses coverage due to a reduction in work hours, including layoffs and strikes.
- When an employee loses coverage due to the voluntary or involuntary termination of employment, including retirement and excluding gross misconduct.

  COBRA coverage is available for employees and their dependents for 29 months from the date of the following qualifying event:

- When the Social Security Administration has determined that an employee or dependent was disabled when coverage was terminated, or within 60 days after the coverage was terminated, due to one of the qualifying events above, and the employee or dependent is still disabled when the 18-month continuation period expires.

COBRA coverage is available for the following individuals for 36 months from the date of the following qualifying events:

- The surviving spouse and surviving children of a covered employee, when the covered employee dies.
- Covered employee, if the employee became eligible for Medicare benefits prior to COBRA election.
- Spouses and dependent children of a covered employee, when the employee and the spouse separate or divorce.
- Dependent children of the covered employee, when the dependent children lose eligibility as dependents.

COBRA coverage is available to children born or placed for adoption during the period of COBRA coverage for the remainder of either the 18-month or 36-month COBRA continuation period. The qualifying event that triggered the COBRA coverage will determine the length of the continuation period for the newborn or adoptee.

COBRA Notification - Unless termination or reduction in hours is the qualifying event, a subscriber, spouse or dependent child must notify the employer of eligibility to continue coverage within 60 days after becoming eligible.

The employer is responsible for notifying the subscriber, spouse and/or dependent child of how to elect continuation coverage. Once notice has been given by the employer, Anthem must receive timely notice from the employer of a member's COBRA election. Anthem must also receive timely payment of appropriate premium charges for a member to be eligible for COBRA.

The COBRA-eligible person has 60 days from the receipt of the employer notification or from the date coverage under the coverage would otherwise end, whichever is later, to elect COBRA coverage and to inform the employer of the election. To apply for COBRA coverage, the eligible person must complete a COBRA or State Continuation of Coverage Application. The employer must complete the employer section, sign the application and submit it to Anthem. After electing COBRA coverage, the subscriber must pay the first premium due within 45 days. For more details, the subscriber may contact the employer.

Termination of State Continuation Coverage or COBRA

A member's continuation coverage terminates when the continuation period is exhausted. The duration of continuation coverage is detailed under the headings "State Continuation Eligibility" and "COBRA Eligibility."

Continuation coverage may terminate before the expiration of the continuation period if:

- The Employer Master Contract between the employer and Anthem is terminated (if the employer selects a replacement group coverage, continuation coverage will continue under the new coverage).
- The member fails to pay premium in a timely manner.
- Under state continuation coverage, the member is eligible for another group health policy unless the other coverage excludes a condition covered by the continued coverage; in which case, the continuation coverage continues until exhausted or the other coverage covers the excluded condition.
- Under COBRA coverage, the member is covered by another group health policy unless the other coverage excludes a condition covered by the continued coverage; in which case, the continuation coverage continues until exhausted or the other coverage covers the excluded condition.
- The member becomes covered by Medicare.
- The member whose COBRA coverage was extended to 29 months is determined under the Social Security Act to no longer be disabled.
- The member submits written notice of voluntary cancellation of coverage.

Conversion Coverage

Subscribers and their eligible dependents who were covered under a group's health program may apply for group conversion **with the same type of coverage** under Anthem's Basic and Standard Plans upon the exhaustion of COBRA or state continuation coverage. In the event that continuation coverage is not available, the subscriber and the eligible dependents must have been covered under the group coverage for at least three months immediately prior to the termination of group coverage to be eligible for this conversion privilege. Conversion coverage is not available if the group health coverage has been discontinued in its entirety. Conversion coverage through Anthem is not available if the election period occurs after the group has replaced this Anthem coverage.

Anthem must receive an application for group conversion coverage within 31 days after group or conversion coverage is terminated. Members must pay the group conversion premium from the date of such termination.

Group conversion coverage is not available to former employees of a group and their dependents in the following situations:

- When an employee is not a group member because the employee was not covered under the group coverage when the coverage was terminated
- When the employee's coverage ends because the employee fails to pay any required contributions
- When a dependent was not covered through the group coverage when the employee's coverage was terminated
- When an employee or dependent is covered by Medicare Part A and/or Part B at the time of eligibility for group conversion coverage. Contact Anthem for coverage options available in this circumstance
- When the employee or dependent is covered for similar benefits by another health benefit coverage or is eligible for similar benefits under any arrangement for coverage for individuals in a group, such that the benefits of the other coverage would result in over-insurance under Anthem's standards.

Note: If a member does not want or is not eligible for group conversion coverage, Anthem will consider applications for enrollment of the member in an individual insurance policy under then-available coverages, rates and benefits. The application is subject to applicable rules for individual coverage.

For groups of 50 or fewer employees, conversion coverage is available to all employees of the group if the group health coverage is terminated by either Anthem or the employer for reasons other than replacement with other group health coverage or fraud and abuse in procuring and utilizing coverage. This conversion coverage privilege will be available even if the group coverage is terminated because the group did not pay premiums. The conversion coverage will be group coverage under Anthem's Basic or Standard Plans. Each employee will receive notice from Anthem of the right to conversion coverage. When the group coverage as a whole is not being terminated; but rather, an individual employee or dependent's group coverage eligibility is being terminated, conversion coverage is available as described above.

Member Benefits

This section describes covered services and supplies. Covered services and supplies are only benefits if they are medically necessary or preventive, not otherwise excluded under this certificate as determined by Anthem and obtained in the manner required by this certificate. All services must be standard medical practice where they are received for the illness, injury or condition being treated, and they must be legal in the United States. The fact that a provider may prescribe, order, recommend or approve a service, treatment or supply does not make it medically necessary or a covered service and does not guarantee payment. The member must contact Anthem for certain services to be sure that preauthorization has been obtained by the ordering provider.

Anthem bases its decisions about preauthorization, medical necessity, experimental/investigational and new technology on medical policy developed by Anthem. Anthem will also consider published peer reviewed medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations, which review the medical effectiveness of health care services and technology.

All covered services are subject to the exclusions listed in this section in addition to those set forth elsewhere in this certificate including those in the **GENERAL EXCLUSIONS** section. All covered services are subject to the other conditions and limitations of this certificate.

Preventive Care Services

This section describes covered services and exclusions for preventive care.

Children

Benefits are provided for periodic routine exams for members based on guidelines from many sources. Exams include a medical history, complete physical examination, developmental assessment and guidance. Having the right exams at the right time may help the member avoid serious illness.

All children age 0-12 years

- Routine immunizations

Age 0-12 Months

- 5 well-child visits
- 1 PKU (phenylketonuria)

Age 13-35 Months

- 2 well-child visits

Age 3-6 years

- 3 well-child visits

Age 7-12 years

- 3 well-child visits

Preventive Care Exclusions — The following services, supplies or care are not covered:

- Visits that exceed the limits above.
- Routine exams related to sports, insurance, school, church or camps.
- Routine care received in the emergency room.
- Immunizations for travel.

Women

Benefits are provided for periodic routine exams (e.g., pelvic exams, breast exams and mammograms) based on guidelines from many sources. Exams shall include a medical history, complete physical examination and medical and preventive guidance, including exercise and nutrition counseling. Having the right exams at the right time may help the member avoid serious illness.

Covered exams follow appropriate state laws applicable to preventive care. Benefits are provided for:

Ages 13 and over

- Annual flu immunization

Ages 13-18

- 1 routine exam every two years.

Ages 19-34

- 1 routine exam every five years.

Ages 35-59

- 1 routine exam every two years.

Ages 60 and over

- 1 routine exam every year.

Age 35-39 years

- 1 baseline mammogram and clinical breast exam.

Age 40 years to 65

- 1 mammogram and clinical breast exam every year.

Benefits for mammograms are allowed up to a maximum payment as required by law for professional and technical evaluation and are not subject to the deductible. Any and all amounts over Anthem's payment are the member's responsibility. The member may reduce the out-of-pocket expense by visiting PPO or participating providers. Anthem may adjust this allowance without advance notice.

Additional mammogram views required for proper evaluation are covered and any ultrasound services for diagnostic screening of breast cancer are also covered, if determined medically necessary by the physician.

Preventive Care Exclusions — The following services, supplies or care are not covered:

- Routine exams and immunizations related to sports, insurance, condition of employment, for licensing, school, church or camp.
- Immunizations for travel.
- Routine care received in the emergency room.

Men

Benefits are provided for periodic routine exams based on guidelines from many sources. Exams shall include a medical history, complete physical examination and guidance, including exercise and nutrition counseling. Having the right exams at the right time may help the member avoid serious illness.

Covered exams follow appropriate state laws applicable to preventive care. Benefits are provided for:

Ages 13 and over

- Annual flu immunization

Ages 13-18

- 1 routine exam every two years.

Ages 19-34

- 1 routine exam every five years.

Ages 35-59

- 1 routine exam every two years.

Ages 60 and over

- 1 routine exam every year.

Age 40 years and over

- 1 prostate specific antigen (PSA) blood test and digital rectal examination every year

Benefits for prostate exams are allowed up to a maximum payment by Anthem of $65 per screening and are not subject to the deductible. Any and all amounts over Anthem's $65 payment up are the member's responsibility. The member may reduce the out-of-pocket expense by visiting PPO or participating providers. Anthem may adjust this $65 allowance annually without advance notice.

Preventive Care Exclusions — The following services, supplies or care are not covered:

- Routine exams and immunizations related to sports, insurance, condition of employment, for licensing, school, church or camp.
- Immunizations for travel.
- Routine care received in the emergency room.

Family Planning

This section describes covered services and exclusions for birth control, surgical sterilization and infertility.

Birth Control

Benefits are provided for:

- Surgical sterilization (e.g., tubal ligation or vasectomy) and related services.

Birth Control Exclusions — The following services, supplies or care are not covered:

- Injections for birth control purposes, fitting of diaphragm or cervical cap, surgical implantation and removal of a contraceptive device, or insertion or removal of an IUD.
- Over the counter products for birth control purpose (e.g., sponges, spermicides and condoms).
- Reversals of sterilization.

Infertility

Benefits are provided to diagnose and treat the actual cause of infertility up to a maximum payment of $2,500 per members benefit year. Covered services include artificial insemination in-vivio with husbands or donor sperm as determined by generally accepted medical practice.

Infertility Exclusions — The following services, supplies or care are not covered:

- Any surgeries, treatments, or services when the obstruction is related to the reversal of a surgical sterilization.
- In-vitro (outside the body in an artificial environment) fertilization with husband or other donor sperm and any related services.
- Cost of donor sperm or donor eggs.
- Diagnostic tests to determine the effectiveness of a procedure designed to promote fertility or pregnancy.
- Storage costs for sperm or frozen embryos.

Maternity and Newborn Care

This section describes covered services and exclusions for maternity and newborn care.

Benefits are provided for maternity and newborn child care, including diagnosis, care during pregnancy and for delivery services. Maternity services include normal vaginal delivery, cesarean section, spontaneous termination of pregnancy prior to full term, therapeutic termination of pregnancy prior to viability, and complications of pregnancy.

Benefits are provided for:

- Inpatient, outpatient and physician office services (including prenatal care) for vaginal delivery, cesarean section, and complications of pregnancy.
- Anesthesia services.
- Routine nursery care for a covered newborn including physician services.
- For covered newborns all medically necessary care and treatment of injury and sickness including medically diagnosed congenital defects and birth abnormalities.
- Circumcision of a covered newborn male .
- Laboratory services related to prenatal care, postnatal care or termination of a pregnancy.
- One routine ultrasound per pregnancy. Additional ultrasounds are based on medical necessity and require preauthorization. See the MANAGED CARE FEATURES heading in **the ABOUT YOUR HEALTH COVERAGE** section for information on preauthorization guidelines.
- Therapeutic termination of pregnancy is a benefit only when the pregnant member or unborn child is endangered and every reasonable effort has been made to save their lives. The procedure must be performed in a hospital or other facility. There must be documentation of at least one of the following conditions:

- The member has a medical condition as determined by the physician, which represents a serious threat to the life of the pregnant member if the pregnancy is allowed to continue; or
- There is a medical condition in the unborn child, as confirmed by two physicians, which would result in the death of the unborn child during the term of the pregnancy of at birth; or
- There is a psychiatric condition, which represents a serious and substantial threat to the life of the pregnant member if the pregnancy continues. The physician must obtain consultation form a licensed physician specializing in psychiatry confirming the presence of such a psychiatric condition unless the pregnant member has been receiving prolonged psychiatric care.

Anthem will not limit coverage for a hospital stay in connection with childbirth for the mother and newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. If the delivery occurs between 8:00 p.m. and 8:00 a.m., and the 48 or 96 hours have passed, coverage will continue until 8:00 a.m. the following morning. The mother's attending physician, after consulting with the mother, may discharge the mother and newborn child earlier if appropriate.

The newborn child must be the child of the subscriber or the subscriber's spouse to be eligible for coverage. If the mother of the newborn child is a covered dependent child of the subscriber, only the mother's services are covered benefits. Any services the newborn child receives are not covered benefits. To learn how to enroll the newborn child of a dependent child, see the DEPENDENTS heading in the **MEMBERSHIP** section for information.

Maternity and Newborn Care Exclusions — The following services, supplies or care are not covered:

- Services including but not limited to preconception counseling, paternity testing, genetic counseling and testing, or testing for inherited disorders, screening for disorders, discussion of family history or test results to determine the sex or physical characteristics of an unborn child.
- Storage costs for umbilical cord blood.

Diabetes Management

This section describes covered services and exclusions for diabetic management.

Benefits are provided to members who have insulin dependent diabetes, non-insulin dependent diabetes and elevated blood glucose levels induced by pregnancy or other medical conditions, when medically necessary.

Benefits are provided for diabetic nutritional counseling, insulin, syringes, needles, test strips, lancets, glucose monitor and diabetic eye exams. Training and education are covered throughout the member's disease course when provided by a certified, registered, or licensed health care professional with expertise in diabetes. Insulin pumps and related supplies are covered subject to meeting Anthem's medical policy criteria. Diabetic supplies and equipment are subject to the annual benefit maximum for medical supplies and equipment as listed on the *Health Plan Description Form*. When diabetic supplies are provided by a pharmacy they are covered under the prescription drug benefits and subject to the prescription copayment and do not apply to the medical equipment and supply benefit maximum.

Diabetes Management Exclusions — The following services, supplies or care are not covered:

- Diabetic supplies and equipment when received from an out-of-network provider.

Physician Office Services

This section describes covered services and exclusions for physician office-based services. In order for the member to receive these benefits, the medical care and services must be received in a physician's office by a physician or other professional provider.

For preventive care refer to the PREVENTIVE CARE SERVICES in this section. For family planning services, including maternity care, refer to the FAMILY PLANNING in this section. For diabetes treatment refer to the DIABETES MANAGEMENT in this section. Refer to the section entitled MENTAL HEALTH AND SUBSTANCE ABUSE CARE for those services covered by Anthem. To receive office services after hours, see the EMERGENCY CARE AND URGENT CARE section for information.

Benefits are provided for medical care, consultations and second opinions to examine, diagnose, and treat an illness or injury when received in a physician's or other professional provider's office. A physician may also provide medication management for medical conditions or mental health disorders. Consultations and second opinions may be provided by another physician at the request of the physician or the member. In certain cases, Anthem may request a second opinion.

Benefits are provided for office-based surgery and surgical services, which include anesthesia and supplies. Such surgical fees include local anesthesia and normal post-operative care. Office-based surgical services are subject to preauthorization guidelines. See the MANAGED CARE FEATURES heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on preauthorization guidelines.

Benefits are provided in a physician's office for diagnostic services when required to diagnose or monitor a symptom, disease or condition including, but are not limited, to the following:

- X-ray and other radiology services.
- Laboratory and pathology services.
- Ultrasound services for non-pregnancy related conditions. For pregnancy-related ultrasounds, see the *Maternity* section for information.
- Allergy tests.
- Audiometric (hearing) and vision tests required for the diagnosis and/or treatment of an accidental injury or an illness.
- Routine vision exam once every 24 months.
- Routine hearing exam, hearing aids and fitting up to a $500 maximum payment every 3 years.

Physician Office Services Exclusions — The following services, supplies or care are not covered:

- Expenses for obtaining medical reports or transfer of files.
- Treatment for hair loss, even if caused by a medical condition, except for alopecia areata.
- Routine foot care such as care for corns, toenails and calluses (except for members with diabetes).
- Telephone or Internet consultations.
- Treatment for sexual dysfunction.
- Genetic counseling.
- Separate reimbursement for anesthesia and post-operative care when services are provided by the same physician in the physician's office.
- Peripheral bone density scans.

Inpatient Facility Services

This section describes covered services and exclusions for acute inpatient care such as hospital, ancillary and professional services. Acute inpatient services may be obtained from an acute care hospital, long term acute care hospital, rehabilitation hospital, or other covered inpatient facility. **All inpatient services are subject to preauthorization or unscheduled admission notification guidelines.** See the MANAGED CARE FEATURES heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on preauthorization guidelines.

Refer to the section entitled MENTAL HEALTH AND SUBSTANCE ABUSE CARE for those services covered by Anthem, including acute medical detoxification. For accident or emergency medical care refer to the EMERGENCY CARE AND URGENT CARE section. For dental services refer to the heading DENTAL RELATED SERVICES for those services covered by Anthem.

Facility services

A broad spectrum of health care services are provided in the inpatient hospital environment. The following are examples of such covered services:

- Charges for semi-private room (with two or more beds), board, and general nursing services. Benefits are provided for the treatment of medical conditions and rehabilitation care, which is part of an acute care hospital stay.
- Use of operating room, recovery room and related equipment.
- Medical and surgical dressings, supplies, surgical trays, casts and splints when supplied by the facility as part of an inpatient admission.
- Prescribed drugs and medicines administered as part of an inpatient admission.
- A room in a special care unit approved by Anthem. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.
- Inpatient rehabilitation benefits for **non-acute hospital admissions** for medically necessary care to restore and/or improve lost functions following an injury or illness are limited to 30 days per the members benefit year.

Ancillary Services

Numerous medical professionals and para-professionals work together in the inpatient hospital environment to provide comprehensive care to patients. The following list includes, but is not limited to, the following examples of such covered ancillary services.

- Diagnostic services such as laboratory and X-ray tests (e.g., CT scan, MRI).
- Chemotherapy and radiation therapy.
- Dialysis treatment.
- Respiratory therapy.
- Charges for processing, transportation, handling and administration of blood. Blood and blood plasma is covered starting from the 3rd pint.

Professional Services

Professional services are those services provided during the inpatient admission by a physician for surgical and medical care. The following list includes, but is not limited to, examples of such covered professional services:

- Physician services for the medical conditions while in the inpatient facility.
- Surgical services. The surgical fee includes normal post-operative care.
- Anesthesia, anesthesia supplies and services for a covered surgery.
- Intensive medical care for constant attendance and treatment when the members condition.
- Surgical assistants or assistant surgeons as determined by Anthem's medical policy. Anthem does not pay for a surgical assistant for all surgical procedures. The list of procedures, which allow a surgical assistant or assistant surgeon, is available to the member's provider.
- Surgical services for the treatment of morbid obesity, which are subject to meeting the criteria included in Anthem's medical policy. The hospital performing the morbid obesity surgery must be designated and approved by Anthem to perform specific covered services provided under this benefit.
- Reconstruction of a breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance. Benefits are provided for physical complications for all stages of mastectomy. If a member chooses not to have surgical reconstruction after a mastectomy, Anthem will provide coverage for an external prosthesis.
- For silicone breast implants benefits are provided for the removal of the implant, implants removed will not be replaced.

Long-Term Acute Care Facility

Long-term acute care facilities are institutions that provide an array of long term critical care services to members with serious illnesses or injuries. Long-term acute care is provided for members with complex medical needs. These include high-risk pulmonary members with ventilator or tracheotomy needs, medically unstable members, extensive wound care or post-op surgery wound members, and low level closed head injury members. Long term acute care facilities do not provide care for low intensity member needs. Authorization for admission and for continued stay is required by Anthem. See the MANAGED CARE FEATURES heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on preauthorization guidelines.

Inpatient Facility Services Exclusions — The following services, supplies or care are not covered:

- The first 3 pints of blood, blood plasma and blood derivatives.
- Room and board and related services in a nursing home or skilled nursing facility.
- If the member leaves a hospital or other facility against the medical advice of the physician, charges related to the non-compliance of care are not eligible for coverage.
- Charges from the facility for the discharge day.
- Surgical benefits will not be provided for subsequent procedures to correct further injury or illness resulting from the member's noncompliance with prescribed medical treatment.
- Procedures that are solely cosmetic in nature. See Anthem's medical policy at www.anthem.com for information on cosmetic services.
- Custodial and/or maintenance care.
- Any services or care for the treatment of sexual dysfunction.

- Sex change operations, preparation for a sex change operation, or complications arising from a sex change operation.
- Personal comfort and convenience items such as televisions, telephone, guest meals, articles for personal hygiene and other similar services and supplies.
- Surgical services for refractive keratoplasty, including radial keratotomy or lasik, or any procedure to correct visual refractive defect.
- Additional procedures that are routinely performed during the course of the main surgery.
- All surgeries for the treatment of morbid obesity that are not performed at a hospital designated and approved by Anthem.

Outpatient Facility Services

This section describes covered services and exclusions in outpatient facilities. Outpatient facility services may be obtained at facilities such as an acute hospital outpatient department, ambulatory surgery center, radiology center, dialysis center, and outpatient hospital clinics. Some outpatient facility services are subject to preauthorization guidelines. See the MANAGED CARE FEATURES heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on preauthorization guidelines.

Refer to the section entitled MENTAL HEALTH AND SUBSTANCE ABUSE CARE for those services covered by Anthem. For emergency care refer to the EMERGENCY CARE AND URGENT CARE heading in this section. For dental services refer to the section entitled DENTAL RELATED SERVICES for those services covered by Anthem.

Facility Services

A broad spectrum of health care services are provided in an outpatient facility setting. The following are examples of such covered services:

- Use of operating room, recovery room and related equipment.
- Medical and surgical dressings, supplies, surgical trays, cast and splints when supplied by the facility as part of an outpatient admission.
- Drugs and medicines when provided as part of an outpatient admission.

Ancillary Services

Numerous medical professionals and para-professionals work together to provide comprehensive care to patients in an outpatient facility. The following includes but is not limited to example of such covered ancillary services.

- Diagnostic services such as laboratory and X-ray tests (e.g., CT scan, MRI).
- Medical and surgical dressings, supplies, surgical trays, or cast and splints when provided in the outpatient department facility.
- Chemotherapy and radiation therapy.
- Dialysis treatment.
- Respiratory therapy.
- Charges for processing, transportation, handling and administration of blood. Blood and blood plasma is covered starting from the 3rd pint.

Professional Services

Professional services are those provided during the outpatient visit by a physician for surgical and medical care for the following:

- Physician services for the medical condition(s) while in the outpatient facility.
- Surgical services. The surgical fee includes normal post-operative care.
- Anesthesia, anesthesia supplies and services for a covered surgery. See Anthem's medical policy at www.anthem.com for definitions of cosmetic services.
- Surgical assistants or assistant surgeons as determined by Anthem's medical policy. Anthem does not pay for a surgical assistant for all surgical procedures.
- Consultation by another physician when requested by the physician. Staff consultation required by facility rules is excluded.

Outpatient Services Exclusions — The following services, supplies or care are not covered:

- The first 3 pints of blood, blood plasma and blood derivatives.
- Surgical benefits for subsequent procedures to correct further injury or illness resulting from the member's noncompliance with prescribed medical treatment.
- Procedures that are solely cosmetic in nature. See Anthem's medical policy at www.anthem.com for information on cosmetic services.
- Any services or care for the treatment of sexual dysfunction.
- Sex change operations, preparation for a sex change operation, or complications arising from a sex change operation.
- Personal comfort and convenience items such as televisions, telephone, guest meals, articles for personal hygiene and other similar services and supplies.
- Surgical services for refractive keratoplasty, including radial keratotomy or lasik, or any procedure to correct visual refractive defect.
- Additional procedures that are routinely performed during the course of the main surgery.
- Peripheral bone density scan.

Emergency Care and Urgent Care

This section describes covered services and exclusions for emergency and urgent care. Emergency care means the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the persons health in serious jeopardy. Urgent care means situations that are not life threatening but require prompt medical attention to prevent serious deterioration in a members health.

Anthem covers emergency services necessary to screen and stabilize a member without preauthorization if a prudent layperson having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed. **Follow-up care received in an emergency department or urgent care center, including but not limited to, removal of stitches and dressing changes, are not considered emergency care**. By choosing an urgent care center when appropriate instead of an emergency room, the member may reduce out-of-pocket expenses.

Emergency Care

Medically necessary emergency care includes emergency accident care and emergency medical care received at a hospital or other facility. Benefits are provided regardless of whether the care is received from a network provider or non-network provider. No prior authorization is necessary. A member should call 9-1-1 in the case of a life or limb-threatening emergency.

Whenever a member is admitted to a facility directly from a hospital emergency room, the emergency room copayment will be waived, however the inpatient hospital copayment will apply to the admission. When a member is admitted to a facility following emergency care **Anthem must be contacted within one business day of admission or as soon as reasonably possible to receive authorization for continued care after the emergency admission.** When Anthem is contacted for authorization for an inpatient stay, the provider and member are notified of the number of days approved for the inpatient stay e.g., the number of days that are considered medically necessary as determined by Anthem's medical policy and guidelines.

Once the member is stabilized, ongoing care and treatment is not emergency care. Continuation of care from an out-of-network provider beyond what is needed to evaluate and/or stabilize the members condition will be considered out-of-network care and paid subject to the out-of-network payment provisions.

Urgent Care

Benefits are provided for accident or medical care received from an urgent care center or other facility such as a physician's office. Urgent care is not considered a life or limb-threatening emergency and does not require the use of an emergency room.

BlueCard Access

When the member is temporarily away from the Anthem service area and needs urgent or after-hours medical care, the member can follow the steps outlined below:

- If a life or limb-threatening emergency, call 9-1-1 or go to the nearest medical facility.
- To find the nearest urgent care facility, the member may call the BlueCard program to find the name and addresses of nearby PPO doctors and hospitals or urgent care facility by calling the phone number listed on the members ID card or by using the BlueCard doctor and hospital finder website at www.BCBS.com.
- If the member is unable to contact the BlueCard program, the member should go to the nearest medical facility.
- The BlueCard program will inform the member whether there is a PPO provider in the area. When the member arrives at the PPO doctor's office, hospital, or urgent care facility, simply present the member health benefit ID card.
- If the member uses a BlueCard provider, the member pays the appropriate payment. If the member does not use a BlueCard provider, the member pays the entire cost of care and will need to submit a claim to Anthem. Anthem will then reimburse the member based on the maximum benefit allowance, less applicable copayment, deductible, and/or coinsurance.

Travel outside the country

In an emergency or urgent care situation the member should go to the nearest health care facility. The member will need to pay the bill in full. Use of a credit card is encouraged because the credit card company will automatically transfer the foreign currency into American dollars. When the member returns home, the member should fill out a claim form, which is available, by contacting Anthem's customer service. The member must submit the claim form along with the receipts to the listed address. The amount submitted must be in American dollars. Anthem may require medical records of the services received. The member is responsible for providing such medical records. It may be necessary for the member to provide an English translation of the medical records.

Emergency Care and Urgent Care Exclusions — The following services, supplies or care are not covered:

- Nonemergency continued care after the member's condition has stabilized.

Ambulance and Transportation Services

This section describes covered services and exclusions for ambulance services. Benefits are provided for local transportation by a vehicle designed, equipped and used only to transport the sick and injured. The vehicle must be operated by trained personnel and licensed as an ambulance to take the member:

- From the members home, scene of an accident or medical emergency to the closest hospital with appropriate emergency facilities.
- Between hospitals for medically necessary transport by ambulance for continuing inpatient or outpatient care.

Ground ambulance is usually the approved method of transportation. Air ambulance is only a benefit when terrain, distance, or the member's physical condition requires the services of an air ambulance. Anthem will determine whether transport by air ambulance is a benefit on a case-by-case basis. If Anthem determines that ground ambulance could have been used, benefits will be limited to ground ambulance benefits. If the member elects not to receive transport to an emergency facility after an ambulance has been called, the members deductible, coinsurance, and/or copayment will still apply.

For ground ambulance the maximum payment by Anthem is $350 per trip. For air ambulance the maximum payment by Anthem is $2,500. Amounts over the $350 or $2,500 payment up are the member's responsibility. The member may reduce the out-of-pocket expense by visiting PPO or participating providers.

Ambulance and Transportation Services Exclusions — The following services, supplies or care are not covered:

- Commercial transport (air or ground), private aviation, or air taxi services.
- Transportation by private automobile, commercial or public transportation or wheelchair ambulance (ambu-cab).
- Ambulance transport if the member could have been transported by automobile, commercial or public transportation without endangering their health or safety.

Outpatient Therapies

This section describes covered services and exclusions for physical therapy, speech therapy, occupational therapy, and cardiac rehabilitation.

Physical therapy may involve a wide variety of evaluation and treatment techniques. Examples include manual therapy, hydrotherapy, heat, or application of physical agents, biomechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, prevent disability following illness, injury, loss of a body part, or congenital defect or birth abnormality. All care must be received from a licensed physical therapist.

Speech therapy is for the correction of speech impairment resulting from illness, injury, or surgery. Speech therapists are also involved in the medical management of swallowing disorders. All care must be received from a licensed speech therapist.

Occupational therapy is the use of constructive activities designed to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living. All care must be received from a licensed occupational therapist.

Up to the members 5th birthday, benefits are provided for 20 outpatient visits each of physical, speech and occupational therapies. Benefits are for the care and treatment of congenital defects and birth abnormalities for covered children without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity.

From the age of 5 years and older, benefits for physical speech and occupational therapies are limited to those recommended by the physician for medical conditions that, in the judgement of the physician and Anthem will result in significant improvement with treatment and would not normally be expected to improve without intervention . Speech therapy benefits are only available for a physician-diagnosed neurological, muscular or structural abnormality involving the organs of speech.

For a cleft palate or cleft lip condition, speech therapy benefits are provided as indicated above for speech therapy and are subject to the limitations above unless additional visits are medically necessary with no age limits. Such speech therapy visits for member's from the age of 5 years and older will reduce the number of speech therapy visits allowed.

Other Outpatient Therapy Services

- Cardiac rehabilitation is a program to restore an individual's functional status after a major cardiac event. Benefits are allowed at a facility for exercise and education under the direct supervision of skilled program personnel in an intensive outpatient rehabilitation program. No more than 36 visits are allowed and the program must start within three months of the major cardiac event and be completed within six months of the major cardiac event.
- Benefits are allowed for services administered by a chiropractor who acts within the scope of licensing for the chiropractic treatment of an illness of accidental injury. Chiropractic benefits are limited to the office visits with manual manipulation of the spine, X-ray of the spine and certain physical modalities and procedures. Benefits are limited to a maximum payment of $750 per member's benefit year.

Therapies Exclusions — The following services, supplies or care are not covered:

- Long term therapy (speech therapy is considered long term if the physician does not believe significant improvement is possible within 60 sessions) for members over the age of 5 years.
- Home programs for on-going conditioning and maintenance.
- Therapies for learning disorders, behavioral or personality disorders, developmental delays, stuttering, voice or rhythm disorders.
- Benefits are not covered for non-specific diagnoses relating to developmental delay and learning-related disorders.
- Therapeutic exercise equipment prescribed for home use such as treadmills and/or weights.
- Membership at health spas or fitness centers.
- Convenience items as determined by Anthem.
- The purchase of pools, whirlpools, spas and personal hydrotherapy devices.
- Services related to worker's compensation injuries.
- Therapies and self-help programs not specifically identified above.

- Recreational, sex, primal scream, sleep and Z therapies.
- Acupuncture.
- Biofeedback.
- Rebirthing therapy.
- Self-help, stress management and weight loss programs.
- Transactional analysis, encounter groups and transcendental meditation (TM)
- Sensitivity training, anger management or assertiveness training.
- Rolfing, pilates, myotherapy or prolotherapy.
- Holistic medicine and other wellness programs.
- Educational programs such as behavior modification or arthritis classes, except as otherwise specifically provided herein.
- Services for sensory integration disorder.
- Occupational therapies for diversional, recreational or vocational therapies (e.g., hobbies, arts and crafts).

Home Health Care/Home IV therapy

Home Health Care

This section describes covered services and exclusions for home health and home infusion therapy (IV) care. Benefits are provided for services performed by a home health agency engaged in arranging and providing nursing services, home health aide services and other therapeutic related services. Home health services are covered only when such services are necessary as alternatives to hospitalization. Prior hospitalization is not required. Home health services must be rendered pursuant to a physician's written order, under a plan of care established by the physician in collaboration with a home health agency. Anthem must preauthorize all services and reserves the right to review treatment plans at periodic intervals.

Covered services include the following for up to 60 visits per members benefit year:

- Professional nursing services performed by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N).
- Certified Nurse Aide services under the supervision of a Registered Nurse of a qualified therapist with professional nursing services.
- Physical therapy provided by a licensed physical therapist.
- Occupational therapy provided by a licensed occupational therapist or certified occupational therapy assistant.
- Respiratory and inhalation therapy services.
- Speech and hearing therapy and audiology services.
- Medical/social services.
- Medical supplies (including respiratory supplies), durable medical equipment (rental or purchase), oxygen, appliances, prostheses and orthopedic appliances.
- Intravenous medications and other prescriptions drugs ordinarily not available through a retail pharmacy.
- Nutritional counseling by a nutritionist or dietitian.

Home infusion/injection therapy

Benefits for home infusion therapy (IV therapy) include a combination of nursing, durable medical equipment and pharmaceutical services in the home. Home IV therapy includes but is not limited to antibiotic therapy, hydration therapy and chemotherapy. Intra-muscular, subcutaneous and continuous subcutaneous injections are also covered services. See the heading FOOD AND NUTRITION for information on Total Parenteral Nutrition (TPN) and enteral nutrition.

Home Health Care Exclusions — The following services, supplies or care are not covered:

- Services of a mental health social worker. Refer to the section entitled MENTAL HEALTH AND SUBSTANCE ABUSE CARE for those services covered by Anthem.
- Services or supplies for personal comfort or convenience including homemaker services.
- Food services, meals, formulas, and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Religious or spiritual counseling.

Hospice Care

This section describes covered services and exclusions for hospice care. Hospice includes medical, physical, social and psychological and spiritual services stressing palliative care for patients.

Covered hospice care can be provided in two environments: 1) the home of the member, or 2) in an inpatient facility.

To be eligible for hospice benefits or inpatient hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending physician. Hospice care is initially approved for a period of three months. Benefits may continue for up to two additional three-month benefit periods. After the exhaustion of three benefit periods, Anthem will work with the physician and hospice to determine the appropriateness of continuing hospice care. Anthem reserves the right to review treatment plans at periodic intervals.

Hospice care services are covered when such services are provided under active management through a hospice which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished. Any services provided in connection with an unrelated illness or medical conditions will be subject to the certificate provisions that apply to other illness or injuries.

Covered services are allowed up to $100 per day for routine home hospice care, including any of the following services:

- Intermittent and 24 hour on-call professional services provided by or under the supervision of a Registered Nurse.
- Intermittent and 24 hour on-call social/counseling services.
- Certified nurse aide services or nursing services delegated to other persons pursuant to applicable state law.
- Benefits are allowed for the following services and are not subject to the dollar limitation specified above:
- Inpatient hospice care.
- Inpatient hospice respite care. Inpatient hospice respite care may be provided only on an intermittent, nonroutine, short-term basis. It is limited to periods of five days or less up to two admissions per member's lifetime.
- Intravenous medications and other prescriptions drugs ordinarily not available through a retail pharmacy.
- Short-term inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management. Benefits are limited to a separate 30-day period.
- Diagnostic testing.
- Transportation.
- Medical supplies (including respiratory supplies), durable medical equipment (rental or purchase), oxygen, appliances, prostheses and orthopedic appliances.
- Bereavement support services for the covered family members during the twelve-month period following the death of the member, limited to a maximum total payment of $1,150.
- Physician services.
- Physical, occupational, speech and respiratory therapies.
- Nutritional counseling by a nutritionist or dietitian.

Hospice Care Exclusions — The following services, supplies or care are not covered:

- Services of a mental health social worker. Refer to the section entitled MENTAL HEALTH AND SUBSTANCE ABUSE CARE for those services covered by Anthem.
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas, and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Pastoral and spiritual counseling.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement, or other legal services.

Human Organ and Tissue Transplant Services

This section describes covered services and exclusions for organ and tissue transplants. Anthem shall provide benefits for human organ and tissue transplant services only with preauthorization by Anthem. The hospital must be designated and approved by Anthem to perform specific covered services provided under this benefit. It should be

noted that not every designated hospital performs each of the specified covered services. In addition, the member must follow all provisions in this benefit program.

Benefits are provided for services directly related to the following transplants:

- Heart
- Lung (single or double)
- Heart-Lung
- Kidney
- Kidney-Pancreas
- Pancreas
- Liver
- Bone marrow transplantation performed in accordance with Anthem 's medical policy
- Peripheral Stem Cell procedures performed in accordance with Anthem's medical policy
- Cornea

A member is eligible for the covered services contained in this section if the following guidelines are met:

- All human organ and tissue transplants must be performed at a hospital designated and approved by Anthem for each specific covered service provided under this section.
- Anthem and the approved hospital must determine that a member is a candidate for any of the covered services specified in this section.
- All human organ and tissue transplants must be preauthorized based upon the clinical criteria and guidelines established, adopted or endorsed by Anthem or its designee in the sole discretion of Anthem. Approval for such covered services will be at the sole discretion of Anthem.
- All hospital admissions that are not a medical emergency are subject to preauthorization by Anthem.
- In the event that the services must be performed based on a medical emergency, Anthem must be notified within 1-business day after admission.

Members who are now eligible for, or who are anticipating receiving eligibility for Medicare benefits are solely responsible for contacting Medicare to determine if the transplant will be eligible for Medicare benefits.

The following are covered services as long as they are preauthorized:

Hospital covered services

- Room and board for a semi-private room. If a private room is used, this benefit program will only provide benefits for covered services up to the cost of the semi-private room rate unless Anthem determines that a private room is medically necessary.
- Services and supplies furnished by the hospital.
- Prescribed drugs used in the hospital.
- Whole blood, administration of blood, and blood processing.
- Medical and surgical dressings and supplies.
- Care provided in a special care unit, which includes all facilities, equipment, and supportive services necessary to provide an intensive level of care for critically ill patients.
- Use of operating and treatment rooms.
- Diagnostic services, which includes a referral for evaluation.
- Rehabilitative and restorative physical therapy services.

Surgical covered services

- Surgical covered services in connection with covered human organ and tissue transplants with preauthorization from Anthem (separate payment will not be made for pre-operative and post-operative services, or for more than one surgical procedure performed at one operative session).
- Services surgical assistant in the performance of such surgery as allowed by Anthem's medical policy.
- Administration of anesthesia ordered by the physician and rendered by a physician or other provider other than the surgeon or assistant at surgery.

Medical covered services

- Inpatient and/or outpatient professional services.

- Intensive medical care rendered to a member whose condition requires a physician's constant attendance and treatment for a prolonged period of time.
- Medical care rendered concurrently with surgery during the hospital stay by a physician other than the operating surgeon for treatment of a medical condition separate from the condition for which the surgery was performed.
- Medical care by two or more physicians rendered concurrently during the hospital stay when the nature or severity of the member's condition requires the skills of separate physicians.
- Consultation services rendered by another physician at the request of the attending physician, other than staff consultations which are required by hospital rules and regulations.
- Home, office and other outpatient medical care visits for examination and treatment of the member.

Other services

- Medically necessary immunosuppressant drugs prescribed for outpatient use in connection with a covered human organ and tissue transplant that are dispensed only by written prescription and that are approved for general use by the Food and Drug Administration, but only if the members coverage has an outpatient prescription drug benefit.
- Transportation costs incurred for travel to and from the site of surgery for covered services. Transportation will be for the member (the transplant recipient) and one other individual accompanying the member, or, if the transplant recipient is a minor child, transportation costs for two other individuals accompanying the member.
- Benefits for transportation and lodging for the transplant recipient and companion(s) limited to a maximum of $10,000 per transplant, not to exceed $100 total per day for reasonable and necessary lodging and meal expenses. The member is responsible for monitoring the accumulation of expenses and for submitting supporting documentation of travel expenses. No benefits will be paid until after the transplant services are received. Coverage is not available for travel costs associated with a pretransplant evaluation if the travel occurs more than one day prior to the actual transplant.
- Transportation of donor organ or tissue.
- Evaluation and surgical removal of the donor organ or tissue and related supplies.

As used in this section, the term donor means a person who furnishes organ tissue for transplantation. If a human organ or tissue transplant is provided from a donor to a transplant recipient, the following apply:

- When both the recipient and the donor are members of Anthem, each is entitled to the covered services specified in this section.
- When only the recipient is a member, both the donor and the recipient are entitled to the covered services specified in this section.
- The donor benefits are limited to those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, grants, foundations, government programs, etc.
- If the donor is an Anthem member, and the recipient is not a covered Anthem member, benefits will not be provided for the donor or recipient expenses.

Covered Services related to the donor and/or donated organ or tissue, such as hospital, surgical, medical, storage and transportation costs are subject to a maximum of $25,000 per transplant. Benefits provided to the donor will be charged against the recipient member's coverage under this certificate and will apply toward the member's lifetime maximum for covered transplants.

No benefits will be provided for procurement of a donor organ or organ tissue which is not used in a covered transplant procedure, unless the transplant is cancelled due to the member's medical condition or death and the organ cannot be transplanted to another person. No benefits will be provided for procurement of a donor organ or organ tissue which has been sold rather than donated.

Only those organ and tissue transplants and directly related procedures specified in this section are covered services under this benefit coverage. Benefits will only be provided for covered services and supplies furnished to the transplant recipient during the period beginning five days before the covered transplant procedure and ends 365 after the covered transplant procedure is performed.

Human Organ and Tissue Transplant Exclusions — The following services, supplies or care are not covered:

- Benefits for services performed at any hospital which is not designated or approved by Anthem to provide human organ and tissue transplant services for the organ or tissue being transplanted.

- Benefits for services if the member is not a suitable candidate as determined by the hospital designated and approved by Anthem to provide such services.
- Benefits for services for donor searches or tissue matching, or personal living expenses related to donor searches or tissue matching, for the recipient or donor, or their respective family or friends
- Any experimental or investigational transplant, treatment, procedure, facility, equipment, drug, device, service, or supply. Any service or supply associated with or provided in follow-up to any of the above.
- Any transplant, treatment, procedure, facility, equipment, drug, device, service, or supply that requires Federal or other governmental agency approval and such approval is not granted at the time services are provided. Any service or supply associated with or provided in follow-up to any of the above.
- Transplants of organs other than those listed above, including non-human organs.
- Services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition that are in any way related to the artificial and/or mechanical heart or ventricular/artrial assist devices or the failure of those devices long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

Medical Supplies and Equipment

This section covered services and exclusions for medical supplies, durable medical equipment, oxygen and equipment for its administration, orthopedic and prosthetic devices. Information on diabetic management supplies that are covered by the plan can be found under the heading DIABETES MANAGEMENT. Supplies are subject to preauthorization guidelines. See the MANAGED CARE FEATURES heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on preauthorization guidelines.

Medical Supplies

Disposable items (except prescription drugs) which are required for the treatment of an illness or injury on an inpatient or outpatient basis received from an Anthem PPO provider are covered. Benefits are provided for syringes, needles, surgical dressings, splints and other similar items that treat a medical condition. For supplies received from a pharmacy, refer to the PRESCRIPTION DRUGS section.

Durable Medical Equipment

Durable medical equipment including such things as crutches, wheelchairs, breathing equipment and hospital beds, are covered if medically necessary and prescribed by a physician. Durable medical equipment generally can withstand repeated use and must serve a medical purpose. The durable medical equipment will be rented or purchased at Anthem's option. Rental costs must not be more than the purchase price and will be applied to the purchase price. Repair of medical equipment, maintenance, and adjustment because of normal usage is covered if the equipment has been purchased by Anthem or would have been approved by Anthem. Other situations will be reviewed on a case by case basis. During repair or maintenance of durable medical equipment, Anthem will provide coverage for replacement rental equipment. Durable medical equipment used as part of an inpatient admission is covered as part of the inpatient hospital admission.

Oxygen and Equipment

Benefits are provided for oxygen and the rental of the equipment needed to administer oxygen (one stationary and one portable unit per member).

Orthopedic Appliances

An orthopedic appliance is a rigid or semi-rigid supportive device that helps to increase the use of a malfunctioning body part or extremity, which limits or stops motion of a weak or poorly functioning body part. An example of an orthopedic appliance is a knee brace. Benefits are provided for the purchase, fitting, needed adjustments and repairs of orthopedic appliances. Covered benefits are limited to the most appropriate model that adequately meets the medical needs of the member.

Prosthetic Devices

A prosthetic device replaces all or part of a missing body part or extremity (leg or arm) to increase the member's ability to function. Benefits are provided for purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices.

Other Appliances

Benefits for other appliances include:

- Either one set of standard prescription eyeglasses or one set of contact lenses (whichever is appropriate for the medical condition) when necessary to replace human lenses absent at birth or lost through intraocular surgery, ocular injury or for the treatment of keratoconus or aphakia. Replacements are only covered if a physician recommends a change in prescription.
- Breast prostheses and prosthetic bras following a mastectomy.
- Routine hearing exam, hearing aids and fitting up to a $500 maximum payment every 3 years.

Medical Supplies and Equipment Exclusions — The following services, supplies or care are not covered:

- Supplies, equipment or appliances, which include comfort, luxury, or convenience items (e.g. wheelchair sidecars, fashion eyeglass frames, or cryocuff unit). Equipment or appliances that the member requests that include more features than needed for the medical condition are considered luxury, deluxe and convenience items (e.g., motorized equipment when manually operated equipment can be used such as electric wheelchairs or electric scooters).
- Any items available without a prescription such as over the counter items and items usually stocked in the home for general use, including but not limited to bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads, and petroleum jelly.
- Air conditioners, purifiers, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical supports and corsets or other articles of clothing, whirlpools, hot tubs, saunas, and biofeedback equipment.
- Self-help devices that are not medical in nature, regardless of the relief or safety they may provide for a medical condition. These include, but are not limited to, bath accessories, home modifications to accommodate wheelchairs, wheel chair convenience items, wheel chair lifts, or vehicle modifications.
- Dental prosthesis, hair/cranial prosthesis, penile prosthesis or other prosthesis for cosmetic purpose.
- Orthotics (except for members with diabetes), whether functional or otherwise, regardless of the relief they provide.
- Home exercise and therapy equipment.
- Hearing aids and related services and supplies.
- Consumer beds or water beds.
- Repair or replacement needed due to misuse or abuse of any covered medical supply or equipment that is identified in this section.
- Orthopedic shoes not attached to a brace (except for members with diabetes).

Dental Related Services

This section covered services and exclusions for accident related dental services, anesthesia for children, inpatient services for dental related services, and cleft palate and cleft lip conditions. Dental services are not covered under this certificate except under the specific circumstances described below. **This certificate provides coverage for medical conditions and should not be considered as the member's dental coverage**. All dental services and supplies are subject to preauthorization guidelines. See the MANAGED CARE FEATURES heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on preauthorization guidelines.

Accident-Related Dental Services

Benefits are provided for accident-related dental expenses when the member meets all of the following criteria:

- Dental services, supplies and appliances are needed because of an accident in which the member sustained other significant bodily injuries outside the mouth or oral cavity.
- The injury occurred on or after the member's effective date of membership.
- Treatment must be for injuries to your sound natural teeth.

- Treatment must be necessary to restore your teeth to the condition they were in immediately before the accident.
- The first dental services must be performed within 90 days after your accident.
- Related services must be performed within one year after your accident. Services after one year are not covered even if coverage is still in effect.

Benefits for restorations are limited to those services, supplies, and appliances Anthem determines to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately before the accident.

Dental Anesthesia

Benefits are provided for general anesthesia, when provided in a hospital, outpatient surgical facility or other facility, and for associated hospital or facility charges for dental care is provided to a dependent child who 1) has a physical, mental or medically compromising condition; 2) has dental needs for which local anesthesia is not effective because of acute infection, anatomic variation or allergy; 3) is extremely uncooperative, unmanageable, uncommunicative or anxious and whose dental needs are deemed sufficiently important that dental care cannot be deferred; or 4) has sustained extensive orofacial and dental trauma.

Inpatient Admission for Dental Care

Benefits are provided for inpatient facility services including room and board, but not including charges for the dental services, **only** if the member has a non-dental-related physical condition, such as bleeding disorders or heart condition that makes the hospitalization medically necessary.

Cleft Palate and Cleft Lip Conditions

Benefits are allowed for inpatient care and medical services, including orofacial surgery, surgical management and follow-up care by plastic surgeons and oral surgeons, orthodontics, prosthetic treatment such as obturators, speech appliances, prosthodontic and surgical reconstruction for the treatment of cleft palate and/or cleft lip. If the member has a dental policy, the dental policy must fully cover orthodontics and dental care subject to the same copayment provisions for the coverage of cleft palate and/or cleft lip as apply to other conditions or procedures covered by the policy.

Dental Surgery

Benefits are provided for inpatient hospitalization, physician, dentist or oral surgeon services, (not including, charges for the dental services) if the member is in a hospital for one of the following reasons:

- Excision of exostosis of the jaw (removal of bony growth).
- Surgical correction of accidental injuries to the jaws, cheek, lips, tongue, floor of the mouth, and soft palate (provided the procedure is not done in preparation for dentures or dental prosthesis).
- Treatment of fractures of the facial bones.
- Incision and drainage of cellulitis (infection of the soft tissue).
- Incision of accessory sinuses, salivary glands, or ducts.

Benefit allowances for surgery include payment for visits to the physician or dentist prior to the surgery, administration of local anesthesia for surgery, and follow-up medical care.

Dental Services Exclusions — The following services, supplies or care are not covered:

- Restoring the mouth, teeth, or jaws because of injuries resulting from biting, chewing, or an accident or injury principally damaging the teeth.
- Restorations, supplies, or appliances. Examples of such non-covered items include but are not limited to: cosmetic restorations, cosmetic replacement of serviceable restorations, and materials (such as precious metal) that are not medically necessary to stabilize damaged teeth.
- Inpatient or outpatient services required due to the age of the member, medical condition and/or nature of the dental services except as described above.
- Upper or lower jaw augmentation or reductions (orthognathic surgery), even if the condition is due to a genetic, congenital or acquired characteristic.
- Artificially implanted devices and bone graft for denture wear.

- Medical or surgical services related to temporomandibular joint therapy or surgery is not covered regardless of medical necessity.
- Administration of anesthesia for dental services, operating and recovery room charges, surgeon services except as allowed above.

Food and Nutrition

This section describes covered services and exclusions for nutrition therapy. Benefits for enteral therapy and Total Parenteral Nutrition (TPN) include a combination of nursing, durable medical equipment and pharmaceutical services. Durable medical equipment and supplies are subject to any benefit maximum as listed on the *Health Plan Description Form*. An in-network licensed therapist or home health agency must provide the nutrition services. All services must be preauthorized, see the MANAGED CARE FEATURES heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on preauthorization guidelines.

Enteral therapy and parenteral nutrition

Enteral nutrition is the delivery of nutrients by a tube into the gastrointestinal tract.

TPN is the delivery of nutrients through an intravenous line directly into the bloodstream.

Nursing visits to assist with enteral nutrition are covered when medically necessary and not considered custodial care under the home health benefits. These services are frequently provided through a home health agency. More information can be found under the heading HOME HEALTH CARE/HOME IV THERAPY and HOSPICE CARE.

Benefits are provided for medical foods for home use for metabolic disorders. These medical foods can be taken either orally or enterally. A provider must have prescribed the medical foods that are appropriate for inherited enzymatic disorders involved in the metabolism of amino, organic, and fatty acids. Such disorders include: phenylketonuria (foods are covered up to age 21 for men and age 35 for women), maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic acidemia and propionic acidemia. This benefit does not include medical foods for members with cystic fibrosis or lactose- or soy- intolerance. All covered medical foods must be obtained through a participating pharmacies and, are subject to the pharmacy copayment.

TPN received in the home is a covered benefit for the first 21 days following a hospital discharge when it is determined to be medically necessary. Additional days may be allowed up to a maximum of 42 days per members benefit year when preauthorized by Anthem.

Food and Nutrition Exclusions — The following services, supplies or care are not covered:

- Enteral feedings.
- Tube feeding formula except as provided above.
- Weight-loss programs, exercise equipment, exercise classes, health club memberships, personal trainers, prescription or over-the-counter medications for weight loss, or obesity treatment (except medically necessary surgical treatment) even if the extra weight or obesity aggravates another condition.
- Food, meals, formulas, and supplements other than those listed above even if the food, meal, formula or supplement is the sole source of nutrition, other than as provided above.
- Breast feeding education and baby formulas.
- Feeding clinics.

Mental Health and Substance Abuse Care

This section covered services and exclusions for biologically based and non-biologically based mental health disorders and substance abuse care.

Biologically based mental illnesses and autism are covered under the member's medical benefits and not subject to the limitations of the mental health benefit. They are covered the same as any other physical illness, and described in the appropriate sections of the certificate depending upon the type care received. Biologically based mental illnesses are schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder, and panic disorder.

Mental health conditions described in this section are for non-biologically based mental health conditions identified as a mental disorder in the most current version of the International Classification of Diseases, in the chapter titled

"Mental Disorders". Mental health condition's are those that have a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition. Services for Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) are covered as mental health conditions if provided by a licensed mental health provider. Benefits are then paid under the mental health benefit. Substance abuse is not considered a mental health condition for the purpose of this benefit; services for substance abuse, which are limited to detoxification and rehabilitation, are described below.

Substance abuse conditions described in this section are for acute medical detoxification and for substance abuse rehabilitation. Substance abuse is a condition develops when an individual uses alcohol and/or other drug(s) in such a manner that the member's health is impaired and/or ability to control actions is lost. The main purpose or medical detoxification of this treatment is to rid the body of toxins, monitor heart rate, blood pressure and other vital signs, manage withdrawal symptoms and administer medications as needed. Benefits are provided for rehabilitation for substance abuse conditions on inpatient or outpatient basis for treatment that will assist the member to live without abusing drugs or alcohol. If the member is admitted for an unscheduled emergency admission, notification requirements can be found below under Preauthorization/Precertifications.

Benefits are provided for medically necessary inpatient care, outpatient care, and provider office services for the diagnosis crisis intervention and treatment of mental health conditions and substance abuse conditions. Inpatient services must be provided by a licensed hospital, psychiatric hospital, alcoholism treatment center, or residential treatment center. Outpatient facility and provider office services must be performed by a physician, licensed clinical psychologist or other professional provider who is properly licensed or certified to practice psychotherapy.

Benefits are provided for medication management for mental health conditions by the member's medical provider, psychiatrist, or prescriptive nurse. If the medication management is provided by the member's medical provider or if the condition is a biologically based mental illness, benefits are covered under the medical benefit. If medication management is provided by a psychiatrist or a prescriptive nurse, benefits are paid under the mental health benefit.

Preauthorizations/Precertifications

The member must contact Anthem's behavioral health administrator to determine medical necessity, appropriate treatment level and appropriate setting. When the member does not obtain prior approval from our behavioral health administrator and does not receive services from the provider designated by that approval, services are not covered. Coinsurance for mental health services are different than coinsurance for medical services. See the *Health Plan Description Form* for coinsurance amounts.

Anthem's behavioral health administrator must be notified for all emergency admissions by the next business day of an admission occurring Sunday through Thursday. Anthem's behavioral health administrator must be notified for all emergency admissions occurring on Friday, Saturdays, and/or holidays, by the next business day.

Inpatient services

Inpatient Services to treat mental health conditions are subject to medical policy and medical necessity. Treatment for inpatient mental health and/or alcoholism conditions are limited to the number of days as listed on the *Health Plan Description Form*. Provider visits received during a covered admission are also covered.

Covered services include but are not limited to:

- Inpatient semi-private room and ancillary services including laboratory and X-ray services.
- Individual psychotherapy.
- Group psychotherapy.
- Psychological testing.
- Family counseling with family members to assist in the members diagnosis and treatment.
- Medication management.
- Provider visits during a covered admission.

Partial hospitalization services

Partial hospitalization services are covered for mental and health conditions and alcoholism. The same services covered for inpatient services are also covered for partial hospitalization. One inpatient day is defined as an admission to a facility for more than 12 hours of treatment. One-partial treatment day is defined as no less than 3 and no more than 12 hours of therapy per day. Partial day treatment is covered only when the member receives care

through a day treatment program. Every two partial day treatments count as one full inpatient day and will be applied against the member's maximum inpatient benefit. For the maximum number of partial hospitalization days, see the *Health Plan Description Form*.

Outpatient services

The same services covered as inpatient services are also covered for outpatient and intensive outpatient program services (except room, board, general nursing and ancillary services) if such services are for less than 3 hours per day for mental health and substance abuse conditions. Benefits are limited to a maximum benefit as described on the *Health Plan Description Form* per members benefit year.

Benefits for outpatient laboratory and radiology services for the diagnosis and treatment of mental health conditions are provided at the same coinsurance level as other mental health conditions.

Mental Health and Substance Abuse Exclusions — The following services, supplies or care are not covered:

- Services or care provided or billed by a school, halfway house, custodial care facility for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
- Residential programs for drug and alcohol rehabilitation, which are not in the Anthem network.
- Partial hospitalization for substance abuse care.
- Private room expenses.
- Biofeedback.
- Psychoanalysis or psychotherapy that a member may use as credit toward earning a degree or furthering his/her education.
- Hypnotherapy.
- Religious, marital and social counseling.
- The cost of any damages to a treatment facility caused by the member.
- Recreational, sex, primal scream, sleep, and Z therapies.
- Self-help, stress management, and weight-loss programs.
- Transactional analysis, encounter groups, and transcendental meditation.
- Sensitivity training, anger management, and assertiveness training
- Behavior modification programs.
- Rebirthing therapy.

Prescription Drugs

This section describes covered services and exclusions for outpatient pharmacy prescription drugs and medications. Anthem allows inpatient pharmacy benefits for prescription drugs when billed by a hospital or other facility for a covered inpatient stay. Refer to the INPATIENT FACILITY SERVICES heading in this section for information on inpatient care. For special foods and formulas for metabolic and nutritional needs refer to the FOOD AND NUTRITION heading for information. Home intravenous (I.V.) therapy is also a benefit as stated under the heading HOME HEALTH CARE/HOME IV THERAPY.

The outpatient pharmacy benefits available under this certificate are managed by Anthem's affiliate, Anthem Prescription Management (APM) which is a pharmacy benefits management company. As part of its services to Anthem, APM offers a nationwide network of retail pharmacies, a mail service pharmacy and clinical services that provides formulary management.

APM, in consultation with Anthem also promotes and enforces the appropriate use of medications by reviewing for improper dosage, potential drug–drug interactions or drug-pregnancy interactions.

The member may review the current formulary on Anthem's website at www.anthem.com, under "Search the drug formulary." The member may also request a copy of the formulary by calling our customer service department at the number listed on the bottom of this page. The formulary is subject to periodic review and amendment. Inclusion of a drug or related item on the formulary is not a guarantee of coverage.

For certain prescription drugs, the prescribing physician may be asked to provide additional information before Anthem will determine medical necessity. Anthem may, at it's sole discretion, establish quantity limits for specific prescription drugs. Covered services will be limited based on medical necessity, quantity limits established by

Anthem, or utilization guidelines. The member's copayment amount depends on whether a formulary or non-formulary drug is obtained and is listed on the *Health Plan Description Form*.

Certain prescription drugs (or the prescribed quantity of a particular drug) may require preauthorization. Preauthorization helps promote appropriate utilization and enforcement of guidelines for prescription drug benefit coverage. At the time the member fills a prescription, the network pharmacist is informed of the preauthorization requirement through the pharmacy's computer system, and the pharmacist is instructed to contact APM. APM uses pre-approved criteria reviewed and adopted by Anthem. APM may contact the prescribing physician if additional information is required to determine whether preauthorization should be granted. For a list of current drugs requiring preauthorization, contact an Anthem customer service representative at the number listed on the bottom of the page, or review on Anthem's website at www.anthem.com. If preauthorization is denied, the member may appeal the decision by following the instructions under found in the **CLAIMS, GRIEVANCES AND APPEALS** section.

The provider or network pharmacist can check with Anthem to verify formulary drugs, any quantity limits, preauthorization requirements, or appropriate brand or generic drugs recognized under the certificate.

Outpatient pharmacy benefits include a therapeutic drug substitution program approved by Anthem and managed by APM. This is a voluntary program designed to inform members and physicians about formulary or generic alternatives to non-formulary or formulary brand drugs. APM may contact the member and the prescribing physician to make the member aware of the formulary or generic drug substitution options. Therapeutic substitutions may also be initiated at the time the prescription is dispensed. Only the member and the physician together can determine whether the therapeutic substitute is appropriate for the member.

Outpatient pharmacy benefits received from a network pharmacy are limited to:

- Prescription drugs, including self-administered injectable drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive drugs and contraceptive devices.
- Certain supplies, equipment and appliances (such as those for diabetes and asthma). The member may contact Anthem to determine approved supplies covered through a pharmacy.
- Smoking cessation prescription drugs up to a the maximum payment as indicated on the *Health Plan Description Form* if the member is enrolled in an Anthem approved smoking cessation-counseling program.

If certain supplies, equipment and appliances are not obtained by mail service or from a network pharmacy, they may be covered medical equipment or supplies under the other sections of this certificate. See the *Medical Supplies and Equipment* section for information.

Each prescription is subject to a copayment. If the prescription order includes more than one covered drug or supply, a separate copayment is required for each covered drug or supply. The copayment will be the lesser of the member's copayment, amount or the retail price charged for the prescription by the pharmacy or mail order service that fills the prescription. The copayment will not be reduced by any discounts, rebates or other funds received by APM from drug manufactures, or similar vendors and/or funds received by Anthem from APM. Anthem will make no payment for any covered drug or supply unless Anthem's negotiated rate exceeds any applicable copayment for which the member is responsible.

The member is limited a 34-day supply of a prescription drug if obtained at a network pharmacy or up to a 90-day supply if received through mail order. For oral contraceptives, members are limited to one pill pack (normally 28 days) at a network pharmacy, or three pill packs by mail order. When medically necessary, a one-month vacation override is available if the member is traveling out of the Anthem service area.

The member must obtain covered prescription drugs and supplies from a network pharmacy. All prescription drugs must be legend to be eligible for benefits. The copayment amount is based upon whether the member obtains a generic or brand name prescription drug and whether formulary or non-formulary prescription legend drugs are dispensed. Members have four tiers of copayments for covered prescription drugs as follows:

Tier-1 — Generic— means a generic prescription drug identified on the formulary by Anthem as a prescription drug with a tier 1 copayment.

Tier-2 — Formulary Brand — means a brand name prescription drug, which Anthem has placed on the formulary as a prescription drug with a tier 2 copayment.

Tier-3 — Non-formulary brand — means a brand name prescription drug, which Anthem has not placed on the formulary and a prescription drug and has a tier 3 copayment

Tier-4 — Self-injectable drugs — Means a self-administered injectable drug that Anthem has placed on the tier 4 list. Such self-administered injectable drugs are subject to the tier 4 30% copayment. The benefits for self-injectable drugs are subject to a maximum copayment as listed on the *Health Plan Description Form* per pharmacy 34-day and per mail service 90-day supply. The list of tier 4 self-administered injectable drugs is available by calling Anthem's customer service department or at Anthem web site www.anthem.com and is subject to change at Anthem's sole discretion.

If the member chooses either a brand name drug on the formulary, or the provider prescribes a formulary brand name drug and a generic formulary drug is available, the member pays the brand formulary tier 2 copayment **plus** the retail cost difference between the brand name drug and the generic substitute. If the member chooses a non-formulary drug, or the provider prescribes a non-formulary drug and a generic formulary drug is available, the member pays the non-formulary tier 3 copayment **plus** the retail cost difference between the non-formulary drug and the generic substitute. Where no generic is available, the member is only responsible for the applicable formulary or non-formulary copayment.

Copayment amounts for prescription drugs, other than those which are flat dollar amounts, are calculated based upon the applicable in-network pharmacy contracted prices for covered prescription drugs and supplies. Copayment amounts for prescription drugs, including self-administered injectable drugs, do not apply towards the annual out-of-pocket limit.

How to Obtain Outpatient Prescription Drug Benefits

How the member obtains benefits depends on whether the member uses a retail or mail service pharmacy.

Network Pharmacy — The member presents the written prescription order from the physician and the member identification card to the pharmacist at a network pharmacy. The pharmacy will file the claim for the member. The member is charged at the point of purchase for applicable copayment amounts.

If the member does not present the health benefit ID card at a network pharmacy, the member will have to pay the full cost of the prescription. If the member does pay the full charge, the member should ask the pharmacist for an itemized receipt and submit it to Anthem with a written request for reimbursement. The member will be reimbursed based on the charge for the covered drug, less the network pharmacy discount payable after review and approval of the claim, less the applicable tier 1, tier 2, tier 3 or tier 4 copayment. Prescription drugs dispensed in excess of a 34-day supply or medication are not reimbursable.

Mail Service — Mail service offers a convenient means of obtaining maintenance prescription drugs by mail if the member takes prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed pharmacy mail service that has entered into a reimbursement agreement with Anthem and are sent directly to the member's home. Maintenance prescription drugs are those used on a continuing basis for the treatment of a chronic illness such as heart disease, high blood pressure, arthritis or diabetes. The member must complete the Order and Patient Profile Form, which is available from customer service or on Anthem's website at www.anthem.com. The member will need to complete the patient profile information only once. The member may mail written prescriptions from the physician, or have the physician fax the prescription to APM's mail service. The member physician may also phone in the prescription to APM's mail service. The member will need to submit the applicable copayment amounts to the APM mail service when the member requests a prescription or refill. For the copayment amount, see the *Health Plan Description Form*. Class II prescription drugs (e.g., narcotics) will only be dispensed in a 34-day supply.

Prescription Drugs and Medicines Exclusions — The following services, supplies or care are not covered:

- Prescription drugs and supplies received from a non-network pharmacy.
- Non-legend prescription drugs.
- Drugs prescribed for weight control or appetite suppression.
- Medication or preparations used for cosmetic purposes to promote hair growth, prevent hair growth, or medicated cosmetics. These included but are not limited to Rogaine®, Viniqa®, and Tretinoin (sold under such brand names as Retin-A®).

- Any drug, product or technology within 6 months of Food and Drug Administration (FDA) approval. Anthem may, at its sole discretion, waive this exclusion in whole or in part for a specific new FDA approved drug product or technology.
- Any medications used to treat infertility.
- Special formulas food, or food supplements (unless for metabolic disorders, see *Food and Nutrition* heading for benefits), vitamins, or minerals, except for legend prenatal vitamins.
- Delivery charges for prescriptions.
- Charges for the administration of any drug unless dispensed in the physician's office or through home health care.
- Drugs which are provided as samples to the provider.
- Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse.
- Hypodermic needles, syringes, or similar devices, except when used for administration of a covered drug when prescribed in accordance with the terms of this section.
- Therapeutic devices or appliances, including support garments and other nonmedicinal supplies (regardless of intended use).
- Nonprescription and over-the-counter drugs, including herbal or homeopathic preparations, and prescription drugs that have over-the-counter bioequivalent even if written as a prescription. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) except for injectable insulin.
- Prescription drugs, which are dispensed in quantities, which exceed the applicable limits, established by Anthem, at its sole discretion.
- Refills in excess of the quantity prescribed by the provider, or refilled more than one year from the date prescribed.
- Prescription Drugs intended for the treatment of sexual dysfunction or inadequacies, regardless of origin or cause (including drugs for the treatment of erectile dysfunction such as Viagra®).
- Nicorette, nicotine patches, or other drugs containing nicotine or other smoking deterrent medications except as provided above.
- Prescription Drugs dispensed for the purpose of international travel.

Private-Duty Nursing Services

Anthem will allow inpatient benefits for private-duty nursing services when the member's condition ordinarily requires that they are placed in an intensive or coronary care unit, but the hospital does not have such facilities. Outpatient benefits are allowed in the member's home other outpatient location.

Private-duty nursing benefits are limited to a maximum combined inpatient and outpatient payment of $2,000 per benefit year, up to a maximum **lifetime** benefit of $5,000 per member, services over the $2,000 annual or $5,000 lifetime payment limits are the member responsibility.

General Exclusions

These general exclusions apply to all benefits described in this certificate. This coverage provides benefits for specific services described in this certificate and not listed as an exclusion. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not covered services. In addition to these general exclusions, specific limitations, conditions and exclusions apply to specific covered services, which can be found in the **MEMBER BENEFITS** section and elsewhere in this certificate.

If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem is the final authority for determining if services and supplies are medically necessary for the purpose of payment.

Anthem will not allow benefits for any of the following services, supplies, situations, or related expenses:

Abortions — This coverage does not cover elective abortions except as provided under MATERNITY AND NEWBORN CARE found in the **MEMBER BENEFITS** section.

Acupuncture — This coverage doe not cover acupuncture, whether for medical or anesthesia purposes.

Alternative or complementary medicines — This coverage does not cover alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aromatherapy, massage therapy, reike therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), clonics or iridology.

Artificial conception — All services related to artificial conception are not covered except as provided under the heading FAMILY PLANNING found in the **MEMBER BENEFITS** section.

Before effective date — This coverage does not cover any service received before the member's effective date of coverage.

Biofeedback — This coverage does not cover biofeedback and related services.

Blood, plasma, or derivatives — This coverage does not cover the first 3 pints of blood, blood plasma and blood derivatives.

Birth Control — This coverage does not cover devices for birth control purposes, their insertion or removal and related services. Examples include but are not limited to, injections for birth control purposes, fitting of diaphragm or cervical cap, surgical implantation and removal of a contraceptive device, insertion or removal of an IUD.

Chelating agents — This coverage does not cover any service, supply, or treatment for which a chelating agent is used, except for providing treatment for heavy metal poisoning.

Clinical research — This coverage does not cover any services or supplies provided as part of clinic research unless allowed by Anthem's medical policy. A signed consent form for human research subjects will be considered proof that a member is involved in a clinical research program.

Complications of non-covered services — This coverage does not cover complications arising from noncovered services and supplies. Examples of non-covered services include but are not limited to, cosmetic surgery, sex-change operations and procedures, which are determined to be experimental/investigational.

Convalescent care — Except as otherwise specifically provided, this coverage does not cover convalescent care from a period of illness, injury, surgery, unless **normally** received for a specific condition, as determined by Anthem's medical policy. Convalescent care includes the physician's or facilities services.

Convenience/luxury/deluxe-services/or equipment — This coverage does not cover services and supplies used primarily for the member's personal comfort or convenience. Such services and supplies include but are not limited to, guest trays, beauty or barber shop services, gift shop purchases, telephone charges, television, admission kits, personal laundry services, and hot and/or cold packs.

This coverage does not cover supplies, equipment or appliances, which include comfort, luxury, or convenience items (e.g. wheelchair sidecars, fashion eyeglass frames, or cryocuff unit). Equipment or appliances the member requests that include more features than needed for the medical condition are considered luxury, deluxe and

convenience items (e.g., motorized equipment when manually operated equipment can be used such as electric wheelchairs or electric scooters) are not covered.

Cosmetic services — This coverage does not cover cosmetic procedures, services, equipment or supplies for psychiatric or psychological reasons, to change family characteristics, to improve appearance or to improve conditions caused by aging. Services required as a result of a complication or adverse outcome of a noncovered cosmetic service. For Anthem's medical policy on cosmetic services, see our website at www.anthem.com or call customer service.

Examples of cosmetic procedures are face lifts, botox injections, breast augmentation, rhinoplasty, or scar revisions.

Court ordered services — This coverage does not cover services that are required under court order, parole or probation unless those services would otherwise be covered under this certificate.

Custodial care — This coverage does not cover care primarily for the purpose of assisting the member in the activities of daily living or in meeting personal rather than medical needs, and which is not a specific treatment for an illness or injury. Custodial care cannot be expected to substantially improve a medical condition, and has minimal therapeutic value. Care can be custodial even if it is recommended or performed by a professional and whether or not it is performed in a facility (e.g., hospital or skilled nursing facility) or at home. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing.
- Transfer or positioning in bed.
- Administration of medication that is usually self-injected.
- Meal preparation.
- Assistance with feeding.
- Oral hygiene.
- Routine skin and nail care.
- Suctioning.
- Toileting.
- Supervision of medical equipment or its use.

Dental services —Dental services are not covered except as provided in **MEMBER BENEFITS** under DENTAL RELATED SERVICES.

Discharge — All inpatient services received after the date Anthem, using managed care guidelines, determines discharge is appropriate.

Discharge against medical advice — This coverage does not cover hospital services if the member leaves a hospital or other facility against the medical advice of the physician.

Discharge day expense — All services related to a discharge day are not covered except as provided in the **MEMBER BENEFITS** section.

Domiciliary care — This coverage does not cover care provided in a residential, non-treatment institution, halfway house or school.

Duplicate (double) coverage — This coverage does not cover services and supplies already covered by other valid coverage, see the heading DUPLICATE COVERAGE AND COORDINATION OF BENEFITS in the **ADMINISTRATIVE INFORMATION** section.

Experimental/Investigative procedures — Any treatment, procedure, drug or device that has not been found by Anthem to meet the eligible-for-coverage criteria**.** The determination that a service is not considered eligible-for-coverage or is experimental/investigational can be made by Anthem either before or after the service is rendered if the service has not been preauthorized. Anthem does not cover treatment or procedures which are experimental/investigational, or which are not proven to be effective as determined by Anthem's medical policy or, if no medical policy is available, as determined by appropriate medical/surgical authorities selected by Anthem.

Genetic testing/counseling — This coverage does not cover services including, but not limited to, preconception, paternity testing, court-ordered genetic counseling and testing, testing for inherited disorders, discussion of family history or testing to determine the sex or physical characteristics of an unborn child). Genetic tests to evaluate risks of disorders

for certain conditions may be covered based on medical policy, review and criteria and after appropriate preauthorization.

Government operated facility — This coverage does not cover services and supplies for all military service connected disabilities furnished by a military medical facility operated by, for, or at the expense of federal, state, or local governments or their agencies, including a veterans administration facility, unless Anthem authorizes payment in writing before the services are performed.

Hair loss — This coverage does not cover treatment for hair loss, drugs, wigs, hair pieces, artificial hairpieces, hair or cranial prosthesis, hair transplants or implants even if there is a physician prescription, and a medical reason for the hair loss.

Hypnosis — This coverage does not cover services related to hypnosis, whether for medical or anesthesia purposes.

Illegal conduct — This coverage does not cover services or supplies for illness or injuries resulting in wholly or partially from conduct attributable to the member which may be deemed a crime or other violation of law.

Intractable pain or chronic pain — This coverage does not cover services or supplies for the treatment of intractable pain and/or chronic pain. Chronic pain is pain of continuous and long-standing duration where the cause cannot be removed.

Learning deficiency and/or behavioral problem therapies — This coverage does not cover services or supplies related to therapies for learning deficiencies and/or behavioral problems except as provided in the **MEMBER BENEFITS** section.

Maintenance therapy — This coverage does not cover any treatment that does not significantly enhance or increase the members function or productivity, or care provided after the member has reached his/her maximum medical improvement, except as provided in the **MEMBER BENEFITS** section.

Medical necessity — This coverage does not cover expenses for services and supplies that are not medically necessary. services may be denied before or after payment unless preauthorization has been received. Anthem's decision as to whether a service or supply is medically necessary is based on medical policy, and peer reviewed medical literature as to what is "approved and generally accepted medical or surgical practice." **The fact that a provider may prescribe, order, recommend, or approve a service does not, of itself, make it medically necessary or an allowable expense, even though it is not specifically listed as an exclusion.**

Missed appointments — This coverage does not cover charges for the member's failure to keep scheduled appointments. The member is solely responsible for such charges.

Neuropsychiatric testing — This coverage does not neuropsychiatric testing unless allowed by Anthem's medical policy.

Noncovered providers of service — This coverage does not cover services and supplies prescribed or administered by a provider or other person, supplies, or facility not specifically listed as covered in this certificate. These non-covered providers or facilities include, but are not limited to:

- Health spa or health fitness centers (whether or not services are provided by a licensed or registered provider).
- School infirmary.
- Halfway house.
- Massage therapist.
- Nursing home.
- Residential institution or halfway house (facility where the primary services are room and board and constant supervision or a structured daily routine for a person who is impaired but whose condition does not require acute care hospitalization).
- Dental or medical services sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group.
- Services provided by the member upon themselves, by a family member, or by a person who ordinarily resides in the member's household.

Nonmedical expenses — This coverage does not cover non-medical expenses, including but not limited to:

- Adoption expenses.

- Educational classes and supplies not provided by the member's provider unless specifically allowed as a benefit under this certificate.
- Vocational training services and supplies.
- Mailing and/or shipping and handling expenses.
- Interest expenses and delinquent payment fees.
- Modifications to home, vehicle, or workplace regardless of medical condition or disability.
- Membership fees for spas, health clubs, personal trainers, or other such facilities even if medically recommended, regardless of any therapeutic value.
- Personal convenience items such as air conditioners, humidifiers, or exercise equipment.
- Personal services such as haircuts, shampoos, guest meals, and radio or televisions.
- Voice synthesizers or other communication devices, except as specifically allowed by Anthem's medical policy.

Orthognathic surgery — This coverage doe not cover upper or lower jaw augmentation or reductions (orthognathic surgery) even if the condition is due to a genetic congenital or acquired characteristic.

Over the counter products — This coverage does not cover any items available without a prescription such as over the counter items and items usually stocked in the home for general use including but not limited to bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads, and petroleum jelly. This coverage does not cover laboratory test kits for home use. These include but are not limited to, home pregnancy tests and home HIV tests.

Post termination benefits — Benefits are not provided for care received after coverage is terminated except as provided in the **MEMEBERSHIP** section.

Private room expenses — All services related to a private room are not covered except as provided in the **MEMBER BENEFITS** section.

Professional courtesy —This coverage does not cover charges for services and supplies when the member has received a professional or courtesy discount from a provider. This coverage does not cover any services where the member's portion of the payment is waived due or professional courtesy or discount.

Radiology services — This coverage does not cover Ultrafast CT scan and peripheral bone density testing. This coverage does not cover the following except as described by medical policy screening or as provided in this certificate, whole body CT scan, routine screening, or more than one routine ultrasound per pregnancy.

Report preparations — This coverage does not cover charges for the preparation of medical reports or itemized bills or charges for duplication of medical records from the provider when requested by the member.

Sex-change operations — This coverage does not cover services or supplies related to sex-change operations, reversals of such procedures, complications of such procedures, or services received prior to any such operation.

Sexual dysfunction — This coverage does not cover services, supplies, or prescription drugs for the treatment of sexual dysfunction or impotence.

Taxes — This coverage does not cover sales, service, or other taxes imposed by law that apply to benefits covered under this certificate.

Temporomandibular joint surgery or therapy — This coverage does not cover surgical or non-surgical services, supplies or appliances related to temporomandibular joint therapy or surgery or orthognathic surgery, including invasive (internal) and non-invasive (external) procedures and tests regardless of the reason(s) such services are necessary.

Third-party liability (subrogation) — This plan does not cover services and supplies which may be reimbursed by a third party, see **ADMINISTRATIVE INFORMATION** section for information.

Travel expenses — This coverage does not cover travel or lodging expenses for the member, members family or the Physician except as provided under HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES heading in the **MEMBER BENEFITS** section.

Vision — This coverage does not cover any eyeglasses, contact lenses (even if there is a medical diagnosis which prevents the member from wearing contact lenses), or prescriptions for such services and supplies. This coverage does not cover any surgical, medical, or hospital service and/or supply rendered in connection with any procedure

designed to correct farsightedness, nearsightedness, or astigmatism. This coverage does not cover vision therapy, including but not limited to, treatment such as vision training, orthoptics, eye training or training for eye exercises.

War-related conditions — This coverage does not cover services or supplies necessary to treat disease or injury resulting from war, civil war, insurrection, rebellion, or revolution.

Weight-Loss Programs — This coverage does not cover services related to weight loss except as provided in the **MEMBER BENEFITS** section.

Workers' compensation — This plan does not cover services and supplies for a work- related accident or illness, see the **ADMINISTRATIVE INFORMATION** section.

Administrative Information

Insurance Premiums

How Premiums are Established and Changed - Premiums are the monthly charges the member and/or employer must pay Anthem to establish and maintain coverage. Anthem determines and establishes the required premiums. The employer is responsible for paying the employee's premium to Anthem according to the terms of the Employer Master Contract. Employers may require their employees to contribute to the premium cost through payroll deduction.

Grace Period - If an employer fails to submit premium payments to Anthem in a timely manner, the employer is entitled to a grace period of 31 days for the payment of such premium. During the grace period, Anthem's contract with the employer shall continue in force unless the employer gives Anthem written notice of termination of the contract. If the employer has obtained replacement coverage during the grace period, the contract will be terminated as of the last day Anthem received premium, and any and **all claims paid during the grace period will be retroactively adjusted**, unless eligibility was verified by the provider within two business days prior to each service received. These claims should be submitted to the replacement carrier. If the employer has **not** obtained replacement coverage during the grace period, or fails to inform Anthem that the employer has not obtained replacement coverage, any and all claims with dates of service during the grace period will be processed by Anthem in accordance with the terms of this certificate.

How to File Claims

When a PPO or participating provider bills Anthem for covered services, Anthem will pay the appropriate charges for the benefit directly to the provider. The member is responsible for providing the PPO or participating provider with all information necessary for the provider to submit a claim. The member pays the applicable copayment to the provider when the covered service is received.

When a member obtains health care services through BlueCard® outside the geographic area Anthem serves, the amount the member pays for covered services is calculated on the **lower** of:

- The billed charges for the covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to Anthem.

Often, this "negotiated price" will consist of a simple discount that reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements, and non-claims transactions with the member's health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with the member's health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount the member pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating member liability for covered services that does not reflect the entire savings realized, or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate member liability calculation methods that differ from the usual BlueCard® method noted above or require a surcharge, Anthem will then calculate the member's liability for any covered services in accordance with the applicable state statute in effect at the time the member received care.

If a non-participating provider does not bill Anthem directly, the member must file the claim. To obtain claim forms, contact Anthem's customer service department. If Anthem does not furnish a claim form to the member within 15 days of the member's request, the member may submit written proof of the claim and will be considered to have complied with the requirements of this certificate. The member must complete the claim form and attach the itemized bill from the provider. Balance due statements, cash register receipts and cancelled checks are not accepted. All information on the claim form and itemized bill must be readable. When traveling outside the country, the member should obtain itemized bills translated to English. Charges for covered services should be stated in terms of United States currency. To determine the United State currency amount, use the exchange rate as it was on the date the member received care. If information is missing on the claim form or is not readable, the form will be returned to the member. The information contained on the itemized bills will be used to determine benefits, so it must support information reported on the submitted claim form. The claim form contains detailed instructions on how to complete the form and what information is necessary.

Anthem is not required to honor an assignment of benefits to non-participating providers. Anthem may honor an assignment of benefits to non-participating providers at Anthem's sole discretion. If Anthem pays the member directly, the member is responsible for paying the non-participating provider of services for all charges.

A separate claim form is required for each non-participating provider for which the member is requesting reimbursement.

A separate claim form is required for each member when charges for more than one family member are being submitted.

Where and When to Send Claims - A claim must be filed **within 365 days** after the date of service. Any claims filed after this limit may be refused. Failure to file a claim within such time will not invalidate or reduce any claim if it is shown that it was not reasonably possible to give such notice and that notice was given as soon as reasonably possible.

Claims will be processed in accordance with the time frame as required by state law for the prompt payment of claims, to the extent such laws are applicable.

Members should make copies of the bills for their own records and attach the original bills to the completed claim form. The bills and the claim form must be submitted to:

Anthem Claims
P.O. Box 17849
Denver, CO 80217-0849

Upon the death of a member, claims will be payable in accordance with the beneficiary designation. If no such designation is in effect, claims payments will be payable to the member's estate. If the provider is a PPO or participating provider, claims payments will be made to the provider.

Payment in Error - If Anthem makes an erroneous benefit payment, Anthem may require the member, the provider of services or the ineligible person to refund the amount paid in error. Anthem reserves the right to correct payments made in error by offsetting the amount paid in error against new claims. Anthem also reserves the right to take legal action to correct payments made in error.

General Provisions

Catastrophic Events - In case of fire, flood, war, civil disturbance, court order, strike or other cause beyond Anthem's control, Anthem may be unable to process member claims on a timely basis. No legal action or lawsuit may be taken against Anthem due to a delay caused by any of these events.

Changes to the Certificate - For employer groups of one to 50, if Anthem amends this certificate to modify benefits, notice of amendment will be given to the employer no less than 90 days prior to the effective date of such change and the amendment(s) will be effective for each group on the renewal or anniversary date of the policy.

For all other modifications, such as modifications due to state or federal law or regulation, Anthem may amend this certificate when authorized by an Anthem officer. Anthem will give the member's employer any amendments within 60 days following the effective date of the amendment. If the employer requests a change that reduces or eliminates coverage, such change must be requested in writing or signed by the employer. The employer will notify the member of such change(s) to coverage. Anthem will subsequently send the member a new certificate.

No agent or employee of Anthem may change this certificate by giving incomplete or incorrect information, or by contradicting the terms of this certificate. Any such situation will not prevent Anthem from administering this certificate in strict accordance with its terms. Oral or written statements do not supercede the terms of this certificate.

Contracting Entity - The subscriber hereby expressly acknowledges that the subscriber understands that the certificate constitutes a contract solely between the subscriber and Anthem, an independent corporation operating under a license from the Blue Cross and Blue Shield Association, which is an association of independent Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield Association permits Anthem to use the Blue Cross and Blue Shield Service Mark, and in doing so, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association. The subscriber further acknowledges and agrees that the subscriber has not entered into the contract based on representations by any person other than an Anthem representative, and that no person, entity or organization other than Anthem will be held accountable or liable to the subscriber for any of Anthem's obligations

created under the certificate. This paragraph does not create any additional obligations whatsoever on Anthem's part other than those obligations created under other provisions of the certificate.

Fraudulent Insurance Acts - It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Insurance fraud results in cost increases for health care coverage. Members can help decrease these costs by doing the following:

- Be wary of offers to waive copayments. This practice is usually illegal.
- Be wary of mobile health testing labs. Ask what the insurance company will be charged for the tests.
- Always review the Explanation of Benefits received from Anthem. If there are any discrepancies, call Anthem's customer service department.
- Be very cautious about giving the member's health insurance coverage information over the phone.

If fraud is suspected, members should contact Anthem's customer service department.

Anthem reserves the right to recoup any benefit payments paid on behalf of a member if the member has committed fraud or material misrepresentation in applying for coverage in or receiving or filing for benefits.

Independent Contractors - Anthem has an independent contractor relationship with Anthem's PPO or participating providers; physicians and other providers are not Anthem's agents or employees, and Anthem's employees are not employees or agents of any of Anthem's PPO or participating providers. Anthem has no control over any diagnosis, treatment, care or other service provided to a member by any facility or professional provider. Anthem is not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the member while receiving care from any of Anthem's PPO or participating providers by reason of negligence or otherwise.

Anthem has an independent contractor relationship with the member's employer. The employer is not Anthem's agent or employee, and Anthem's employees are not employees or agents of the employer.

Anthem may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs and mental health/behavioral health and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims payment or customer service duties on Anthem's behalf.

Network Access Plan - Anthem strives to provide an extensive provider network in Colorado that adequately addresses members' health care needs. The Network Access Plan describes Anthem's provider network standards for network sufficiency in service, access and availability, as well as assessment procedures Anthem follows in Anthem's effort to maintain adequate and accessible networks. To request a copy of this document, call Anthem's customer service department at the number printed at the bottom of this page. This document is available on Anthem's website or for in-person review at 700 Broadway in Denver, Colorado, in the customer service department.

Non-Contestable - This certificate shall not be contested, except for nonpayment of premiums by the employer, after it has been in force for two years from its date of issue. No statement made to effect coverage under the certificate with respect to a member shall be used to avoid the insurance with respect to which statement was made or to reduce benefits under such certificate after such insurance had been in force for a period of two years during such member's lifetime, unless such statement is contained in a written instrument signed by the member making such statement and a copy of that instrument is or has been furnished to the member making the statement or to the beneficiary of any such member.

Notice of Privacy Practices – Anthem is committed to protecting the confidential nature of members' medical information to the fullest extent of the law. In addition to various laws governing member privacy, Anthem has its own privacy policies and procedures in place designed to protect member information. Anthem is required by law to

provide individuals with notice of Anthem's legal duties and privacy practices. To obtain a copy of this notice, visit Anthem's website or contact Anthem's customer service department.

No Withholding of Coverage for Necessary Care - Anthem does not compensate, reward or incent, financially or otherwise, Anthem's associates for inappropriate restrictions of care. Anthem does not promote or otherwise provide an incentive to employees or physician reviewers for withholding benefit approval for medically necessary services to which the member is entitled. Utilization review and benefit coverage decision making is based on appropriateness of care and service and the applicable terms of this certificate.

Anthem does not design, calculate, award or permit financial or other incentives based on the frequency of: (1) denials of authorization for coverage; (2) reductions or limitations on hospital lengths of stay, medical services or charges; or (3) telephone calls or other contacts with health care providers or members.

Paragraph Headings - The headings used throughout this certificate are for reference only and are not to be used by themselves for interpreting the provisions of the certificate.

Physical Examinations and Autopsies - Anthem has the right and opportunity, at Anthem's expense, to request an examination of the person covered by Anthem when and as often as it may reasonably be required during the review of a case or claim. On the death of a member, Anthem may request an autopsy where it is not forbidden by law.

Research Fees - Anthem reserves the right to charge an administrative fee when extensive research is necessary to reconstruct information that has already been provided to the member in explanations of benefits, letters or other documents.

Reserve Funds - No member is entitled to share in any reserve or other funds that may be accumulated or established by Anthem, unless Anthem grants a right to share in such funds.

Sending Notices - All subscriber notices are considered sent to and received by the subscriber when deposited in the United States mail with postage prepaid and addressed to either:

- The subscriber at the latest address in Anthem's membership records.
- The subscriber's employer, if applicable.

Statement of ERISA Rights - The group health care coverage provided by the employer may be offered as part of an employee welfare benefit coverage governed by the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About the Coverage and Benefits. All plan participants may:

- Examine, without charge, at the plan administrator's office or other specified locations, all documents governing the coverage and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the subscriber, member and other plan participants and beneficiaries. No one, including the subscriber's employer, or any other person, may fire the subscriber or otherwise discriminate against the subscriber in any way to prevent him/her from obtaining a welfare benefit or exercising rights under ERISA.

If a member's claim for a benefit is denied or ignored, in whole or in part, the member has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. The member must follow the procedures set forth in the **COMPLAINTS, APPEALS AND GRIEVANCES** section.

Under ERISA, there are steps the member can take to enforce the above rights. For instance, if the member requests a copy of plan documents or the latest annual report from the plan and does not receive them within 30 days, the

member may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay the member up to $110 a day until the member receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If the member has a claim for benefits which is denied or ignored, in whole or in part, the member may file suit in a state or Federal court, after having exhausted the procedures set forth in the **COMPLAINTS, APPEALS AND GRIEVANCES** section. If it should happen that plan fiduciaries misuse the plan's money, or if the member is discriminated against for asserting the member's rights, the member may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court. The court will decide whom, if anyone should pay court costs and legal fees. If the member is successful the court may order the other party(ies) to pay these costs and fees. If the member should lose, the court may order the member to pay these costs and fees.

Assistance with Questions

If a member has any questions about the plan, or whether it is a plan governed by ERISA the member should contact the plan administrator. If the member has any questions about this statement or about the member's rights under ERISA, or if the member needs assistance in obtaining documents from the plan administrator, the member should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The member may also obtain certain publications about the member's rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Workers' Compensation

To recover benefits under workers' compensation insurance for a work-related illness or injury, the member must pursue the member's rights under the Workers' Compensation Act or any of the employer liability laws that may apply. This includes filing an appeal with the Division of Workers' Compensation. Anthem may pay conditional claims during the appeal process if the member signs a reimbursement agreement to reimburse Anthem for 100 percent of benefits paid that duplicate benefits paid from another source.

Services and supplies resulting from work-related illness or injury are not a benefit under this certificate, except for corporate officers who may opt out of Workers' Compensation coverage, pursuant to state or federal law. This exclusion from coverage applies to expenses resulting from occupational accident(s) or sickness(es) covered under:

- Occupational disease laws
- Employer's liability insurance
- Municipal, state, or federal law
- Workers' Compensation Act

Anthem will not pay benefits for services and supplies resulting from a work-related illness or injury **even if other benefits are not paid because:**

- The member fails to file a claim within the filing period allowed by the applicable law.
- The member obtains care that is not authorized by workers' compensation insurance.
- The member's employer fails to carry the required workers' compensation insurance. In this case, the employer becomes liable for any of the employee's work-related illness or injury expenses.
- The member fails to comply with any other provisions of the Workers' Compensation Act.

Automobile Insurance Provisions

Anthem will coordinate the benefits of this certificate with the benefits of a complying automobile insurance policy.

A complying automobile insurance policy is an insurance policy approved by the Colorado Division of Insurance that provides at least the minimum coverage required by law, and one which is subject to the Colorado Auto Accident Reparations Act or Colorado Revised Statutes §§ 10-4-601 through 10-4-633. Any state or federal law requiring similar benefits through legislation or regulation is also considered a complying policy.

How Anthem Coordinates Benefits with Complying Policies - Member benefits under this certificate may be coordinated with the coverages afforded by complying policy. After any primary coverages offered by the complying policy are exhausted, Anthem will pay benefits subject to the terms and conditions of this certificate. If

there is more than one complying policy that offers primary coverage, each will pay its maximum coverage before Anthem is liable for any further payments.

Members must fully cooperate with Anthem to make sure that the complying policy has paid all required benefits. Anthem may require members to take a physical examination in disputed cases. If there is a complying policy in effect, and the member waives or fails to assert the member's rights to such benefits, this plan will not pay those benefits that could be available under a complying policy.

Anthem may require proof that the complying policy has paid all primary benefits prior to making any payments to the member. Alternatively, Anthem may but is not be required to pay benefits under this certificate and later coordinate with or seek reimbursement under the complying policy. In all cases, upon payment, Anthem is entitled to exercise its rights under this certificate and under applicable law against any and all potentially responsible parties or insurers. In that event, Anthem may exercise the rights found in the **ADMINISTRATIVE INFORMATION** section, under the heading *Third Party Liability: Subrogation*.

What Happens If a Member Does Not Have Another Policy – Anthem will pay benefits for injuries received by the member while the member is riding in or operating a motor vehicle that the member owns if the vehicle is not covered by an automobile complying policy as required by law.

Anthem will also pay benefits under the terms of the certificate for injuries sustained by a member who is a non-owner-operator, passenger or pedestrian involved in a motor vehicle accident if that member's injuries are not covered by a complying policy. In that event, Anthem may exercise the rights found in the **ADMINISTRATIVE INFORMATION** section, under the heading *Third Party Liability: Subrogation*.

Third Party Liability: Subrogation

Third-party liability exists when someone other than the member is legally responsible for the member's condition or injury. Anthem will not pay for any services or supplies under this certificate for which a third party is liable.

Anthem may, however, provide benefits under these conditions:

- When it is established that a third-party liability does not exist.
- When the member guarantees in writing to reimburse Anthem for any claims paid by Anthem on the member's behalf if the third party later settles with the member for any amount, or if the member recovers any damages in court.

Anthem's Rights Under Third-Party Liability - When a third party is or may be liable for the costs of any covered expenses payable to the member or on the member's behalf under this certificate, Anthem has subrogation rights. This means that Anthem has the right, either as co-plaintiffs or by direct suit, to enforce the member's claim against a third party for the benefits paid to the member or on the member's behalf.

Member Obligations Under Third-Party Liability – The member has an obligation to cooperate in satisfying Anthem's subrogation interest or to refrain from taking any action that may prejudice Anthem's rights under this certificate. If Anthem must take legal action to uphold Anthem's rights and if Anthem prevails in that action, Anthem will be entitled to receive, and the member will be required to pay, Anthem's legal expenses, including attorneys' fees and court costs.

If a third party is or may be liable for any expenses payable to a member or on a member's behalf under this certificate, then the following must occur:

- The member must promptly notify Anthem of the member's claim against the third party.
- The member and the member's attorney must provide for the amount of benefits paid by Anthem in any settlement with the third party or the third party's insurance carrier.
- If the member receives money for the claim by suit, settlement or otherwise, the member must fully reimburse Anthem for the amount of benefits provided to the member under this certificate. The member may not exclude recovery for Anthem's health care benefits from any type of damages or settlement recovered by the member.
- The member must cooperate in every way necessary to help Anthem enforce Anthem's subrogation rights.

NOTE: Failure to comply with obligations in this section may result in termination of coverage under this certificate.

Duplicate Coverage and Coordination of Benefits

Anthem coordinates benefits when a member has coverage with more than one health coverage.

Duplicate Coverage - Duplicate coverage is the term used to describe when a member is covered by this coverage and is also covered by another group or group-type health insurance or health benefits coverage or blanket coverage. The total benefits received by a member, or on a member's behalf, from all coverages combined for any claim for covered services will not exceed 100 percent of the total covered charges.

How Anthem Determines Which Coverage is Primary and Which is Secondary - Anthem will determine the primary coverage and secondary coverage according to the following rule: A coverage is primary if it does not have order of benefit determination rules or if it has rules that differ from those permitted by state law.

Duplicate Coverage on Members - A coverage is primary if the member claiming benefits is the person in whose name the policy is issued but who is not a dependent under that coverage (except when covered by Medicare or COBRA).

The benefits of a coverage which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) is primary before those of a coverage which covers that person as a laid-off or retired employee (or as that employee's dependent).

When a member (including dependent family members) has duplicate coverage carried through two or more employers, the policy that has been in force the longest period of time is primary. The policy that has been in force the shortest period of time is secondary.

When the coverage through one of the employers is a COBRA policy and one of the coverages is through active employment, the coverage through active employment is primary.

NOTE: Change in administrators is considered continuous coverage. Therefore, the effective date of the coverage in that group is the effective date with the original carrier who provided insurance, as long as there were no lapses in coverage. Information on coordinating benefits for members who hold two insurance policies and Medicare can be found under the heading "Members with Medicare and Two Group Insurance Policies."

Duplicate Coverage on Spouses - When a member's spouse has group coverage through an employer and is actively working, that coverage is primary for the spouse.

When the coverage carried by the spouse is through retiree or inactive employment, that coverage will be primary over the coverage carried by the Anthem policyholder.

When the spouse's coverage through the employer is a COBRA policy and Anthem's coverage is active, then the spouse's coverage will be secondary to the Anthem policy.

Note: Information on coordinating benefits for members who hold two insurance policies and Medicare can be found under the heading "Members with Medicare and Two Group Insurance Policies."

Duplicate Coverage on Dependent Children (when parents are not separated or divorced) - If both coverages cover the member as a dependent, the benefits of the coverage of the parent whose birthday occurs earlier in the year is primary ("birthday rule") over those of the coverage of the parent whose birthday falls later in that year. However, if both parents have the same birthday (month and day, not year), then the benefits of the coverage that has covered **the parent** and dependent(s) longest is primary over the coverage which has covered the **other parent** and dependent(s) for a shorter period of time.

If either insurance policy does not follow the birthday rule, the male policyholder's insurance is the primary policy.

Duplicate Coverage on Dependent Children (when parents are separated or divorced) - Anthem requires a copy of the divorce decree to establish primacy on children of divorced parents.

When the specific terms of a court decree state that one of the parents is responsible for providing health insurance for the child that insurance policy is primary. The insurance policy of the other parent is the secondary coverage.

The insurance policy of the parent with legal custody of the child is primary. When the parent with custody remarries, the custodial parent's coverage remains primary. The stepparent's coverage becomes secondary, and the coverage of the parent without custody pays **after** the stepparent's coverage.

The birthday rule (benefits of the coverage of the parent whose birthday occurs earlier in the year are primary) applies when the specific terms of the court decree state that the parents share joint custody and both must provide health insurance.

The birthday rule applies when the specific terms of the court decree state that the parents share joint custody, without stating which parent is responsible for providing health insurance for the child.

When the divorce decree states that one of the parents is responsible for providing health insurance and the parents share joint custody, then the parent providing the coverage will be primary.

How Anthem Coordinates Benefits - When Anthem is the primary coverage, Anthem pays benefits under the terms of this certificate. When Anthem is the secondary coverage, Anthem may pay up to the difference between benefits that would be payable by the primary coverage and the amount that would be payable under this certificate in the absence of a coordination of benefits provision, so long as that difference is not more than Anthem would normally pay. Benefits provided under any other coverage include benefits that would have been provided had a claim been made for these benefits.

Determining Primacy Between Medicare and Anthem – Anthem will be the primary payer for persons with Medicare age 65 and older if the policyholder is actively working for an employer who is providing the policy holder's health insurance and the employer has 20 or more employees. Medicare will be the primary payer for persons with Medicare age 65 and older if the policyholder is not actively working or the employer has less than 20 employees.

Anthem will be the primary payer for persons with Medicare under age 65 when Medicare coverage is due to disability if the policyholder is actively working for an employer who is providing the policy holder's health insurance and the employer has 100 or more employees. Medicare will be the primary payer for persons with Medicare due to disability if the policyholder is not actively working or the employer has less than 100 employees.

Anthem will be the primary payer for persons with Medicare under age 65 when Medicare coverage is due to End Stage Renal Disease (ESRD), for the first 30 months from the ***entitlement to*** or ***eligibility for*** Medicare (whether or not Medicare is taken at that time). After 30 months, Medicare will become the primary payer if Medicare is in effect (30-month coordination period).

At the point when a member becomes eligible for Medicare due to a second entitlement (such as age), Anthem remains primary, if the group health coverage was primary at the point when the second entitlement became effective, for the duration of 30 months after the Medicare entitlement or eligibility due to ESRD. If Medicare was primary at the point of the second entitlement, then Medicare remains primary. There will be no 30-month coordination period for ESRD.

Members with Medicare and Two Group Insurance Policies - If Medicare is secondary to a group coverage (see Medicare primacy rules), the primary coverage covering the member will pay first, Medicare will pay second, and the coverage covering the member as a retiree or inactive employee or dependent will pay third. The order of primacy is not based on the policyholder of the group health insurance.

If Medicare is the primary payer due to Medicare primacy rules, then the rules of primacy for employees and their spouses will be used to determine the coverage that will pay second and third. The rules of primacy can be found under the heading "Double Coverage on Spouses."

Member Obligations - Members have an obligation to provide Anthem with current and accurate information regarding the existence of other coverage.

Benefits payable under another coverage include benefits that would be payable under that coverage, whether or not a claim is made, and benefits that would have been paid but were refused because the claim was not sent to the provider of other coverage on a timely basis.

Member benefits under this certificate will be reduced by the amount that such benefits would duplicate benefits payable under the primary coverage.

Anthem's Rights to Receive and Release Necessary Information - Anthem may release to, or obtain, from any insurance company or other organization or person any information which Anthem may need to carry out the terms of this certificate. Members will furnish to Anthem such information as may be necessary to carry out the terms of this certificate.

Payment of Benefits to Others - Whenever payments which should have been made under this certificate have been made under any other coverage, Anthem will have the right to pay to the other coverage any amount Anthem determines to be warranted to satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this certificate, and with that payment Anthem will fully satisfy Anthem's liability under this provision.

Anthem's Right of Overpayment Recovery - If Anthem has overpaid for covered services under this provision, Anthem will have the right, by offset or otherwise, to recover the excess amount from the member or any person or entity to which, or in whose behalf, the payments were made.

Complaints, Appeals and Grievances

This section explains what to do if a member disagrees with Anthem's denial, in whole or in part, of a claim, requested service or supply and includes instructions on initiating a complaint, filing an appeal or filing a grievance with Anthem.

Complaints

If a member has a complaint about any aspect of Anthem's service or claims processing, the member should contact Anthem's customer service department. A trained representative will work to clear up any confusion and resolve the member's concerns. A member may submit a written complaint to the address listed below. If the member is not satisfied with the resolution of their concerns by the Anthem customer service associate, the member may file an appeal as explained under the heading A*ppeals* in this section:

Anthem
Customer Service Department
P.O. Box 5425
Denver, CO 80217-5425

Appeals

While Anthem encourages members to file appeals within 60 days of the adverse benefit determination, the member's written appeal must be received by Anthem within 180 days of the adverse benefit determination. Anthem will assign a Customer Advocate to assist the member in the appeal process. Members may send written appeals to the following address:

Anthem
Appeals Department
700 Broadway CAT 0430
Denver, CO 80273-0001

An appeal may be filed with or without first submitting a complaint. In the appeal, the member must state plainly the reason(s) why the claim or requested service or supply should not have been denied. The member should include any documents not originally submitted with the claim or request for the service or supply and any information that may have a bearing on Anthem's decision.

For a thorough, unbiased review, the member may access two internal levels of appeal. In the case of a benefit denial based on utilization review, an independent external review appeal is also available to the member.

Members may designate a representative (e.g., the member's physician or anyone else of the member's choosing) to file any level of appeal review with Anthem on the member's behalf. The member must give this designation to Anthem in writing.

Level 1 Appeal — This is an appeal in which Anthem appoints an internal person(s) not involved in the initial determination to review the denial of the claim, requested service or supply. A person that was previously involved with the denial may answer questions. The person(s) appointed to review a Level 1 Appeal involving utilization review shall consult with an appropriate clinical person(s) in the same specialty as would typically manage the case being reviewed. For utilization review issues, the member will receive a response to the member's Level 1 Appeal within 20 workdays of receipt of the appeal request. Non-utilization review appeals will typically be resolved within 30 workdays.

Level 2 Appeal — This is an appeal of an adverse benefit determination that has not been resolved to the member's satisfaction under the Level 1 Appeal process. The Level 2 Appeal must be requested within 60 calendar days after the member receives Anthem's adverse determination from the Level 1 Appeal. The member may appear or be teleconferenced in to present testimony, introduce documentation the member believes supports their appeal and provide documentation requested by Anthem at a hearing concerning the appeal.

The panel of reviewers shall include a minimum of three people and may be composed of Anthem associates who have appropriate professional expertise. A majority of the panel shall be comprised of persons who were not previously involved in the dispute; however, a person who was previously involved with the dispute may be a member of the panel or appear before the panel to present information or answer questions. In the case of utilization

review appeals, the majority of the persons reviewing the appeal shall be health care professionals who have appropriate expertise. Such reviewing health care professionals shall meet the following criteria:

- Have not been involved in the care previously.
- Is not a member of the board of directors of the health plan.
- Have not been involved in the review process for the covered person previously.
- Do not have a direct financial interest in the case or in the outcome of the review.

Anthem will issue a copy of the written decision to the member and to the provider who submits an appeal on the member's behalf, if any, within 50 workdays of Anthem's receipt of the Level 2 Appeal request.

Expedited Appeals — A member or member's representative has the right to request an expedited appeal of a utilization review decision when the time frames for a standard review would: seriously jeopardize the life or health of the covered person; jeopardize the covered person's ability to regain maximum function; or for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently. Typically the decision will be made within 72 hours. Expedited appeals will be evaluated by an appropriate clinical peer or peers who were not involved in the initial denial. Anthem will not provide an expedited review for retrospective denials.

Independent External Review Appeals — Independent External Review Appeals are conducted by independent external review entities, which are selected by the Colorado Division of Insurance. Independent External Review Appeals are available only in those circumstances where claims or requested services or supplies were denied based on utilization review and which have gone through Anthem's Level 2 Appeal process. To request an Independent External Review Appeal, the member or member's representative must complete and submit a written request on a form entitled "Request for Independent External Review of Carrier's Final Adverse Determination". This form is available through Anthem's customer service department. The request must be made to Anthem within 60 calendar days after the date of receipt of notice of Anthem's Level 2 Appeal denial. The Division of Insurance will assign an independent external review entity to conduct the review. The independent reviewer's decision will be made within 30 workdays after Anthem receives a request for such a review. This timeframe may be extended up to 10 workdays for the consideration of additional material if requested by the independent external review entity.

Expedited Independent External Review Appeals — Expedited Independent External Review Appeals reviews may be requested by a member or the member's representative if the member has a medical condition where the timeframe for a standard independent external review appeal would: seriously jeopardize the life or health of the covered person; jeopardize the covered person's ability to regain maximum function; or for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently. The member's request must include a physician's certification that the member's medical condition meets the criteria for an Expedited Independent External Review Appeal. The request must be made on the form referenced in the paragraph above. Determinations will be made by the independent external review entity within seven working days after Anthem receives a request for an Expedited Independent External Review Appeal. This timeframe may be extended for an additional five working days for the consideration of additional information if requested by the independent external review entity. An Expedited Independent External Review Appeal may not be provided for retrospective denials.

Grievances

A member may send a written grievance to the following address:

Anthem
Quality Management Department
700 Broadway MC0532
Denver, CO 80273

Receipt of the member's grievance will be acknowledged by Anthem's Quality Management Department and the grievance will be investigated by Anthem's Quality Management Department. Anthem treats each grievance investigation in a strictly confidential manner.

Division of Insurance Inquiries

For inquiries about health care coverage in Colorado, members may call the Division of Insurance between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday, at (303) 894-7490, or write to the Division of Insurance to the attention of the ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202.

Binding Arbitration

The binding arbitration provision is applicable to claims arising under all individual plans, governmental plans, church plans, plans or claims to which ERISA preemption does not apply, and plans maintained outside the United States. Any such arbitration will be governed by the procedures and rules established by the American Arbitration Association, provided however, that no formal discovery shall be allowed, unless agreed to by the parties. Members may obtain a copy of the Rules of Arbitration by calling Anthem's customer service department. The law of the state in which the policy was issued and delivered to the member shall govern the dispute. The decision in arbitration is binding upon both the member and Anthem. Judgement on the award given in arbitration may be enforced in any court that has proper jurisdiction. In the event any person subject to this arbitration clause initiates legal action of any kind, Anthem may apply for a court of competent jurisdiction to enjoin, stay or dismiss any such action and direct the parties to arbitrate in accordance with this provision.

Damages, if any, are limited to the amount of the benefit payment in dispute plus reasonable costs. Anthem is not liable for punitive damages or attorney fees.

Legal Action

Before a member takes legal action on a claim decision, the member must first follow the process outlined under the heading A*ppeals* in this section and the member must meet all the requirements of this certificate.

No action in law or in equity shall be brought to recover on this certificate prior to expiration of 60 calendar days after a claim has been filed in accordance with the requirements of this certificate. No such action shall be brought at all unless brought within three years after claim has been filed as required by the certificate.

Glossary

This section defines words and terms used throughout the certificate to help members understand the content. Members should refer to this section to find out exactly how, for the purposes of this certificate, a word or term is used.

Accidental injuries — unintentional internal or external injuries, e.g., strains, animal bites, burns, contusions and abrasions which result in trauma to the body. Accidental injuries are different from illness-related conditions.

Acupuncture services — the treatment of a disease or condition by inserting special needles along specific nerve pathways for therapeutic purposes. The placement of the needles varies with the disease or condition being treated.

Acute care — care that is provided in an office, urgent care setting, emergency room or hospital for a medical illness, accident or injury. Acute care may be emergency, urgent or non-urgent, but is not primarily preventive in nature.

Alcoholism/substance treatment center — a detoxification and/or rehabilitation facility licensed by the state to treat alcoholism/drug abuse.

Alternative/complimentary care — therapeutic practices that are not currently considered an integral part of conventional medical practice. Therapies are termed *Complimentary* when used in addition to conventional treatments and as *Alternative* when used instead of conventional treatment. Alternative medicine includes, but is not limited to, Chinese or Ayurvedic medicine, herbal treatments, vitamin therapy, homeopathic medicine and other non-traditional remedies for treating diseases or conditions.

Ambulance — a specially designed and equipped vehicle used **only** for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

Ancillary services — services and supplies (in addition to room services) that hospitals, alcoholism treatment centers and other facilities bill for and regularly make available for the treatment of the member's condition. Such services include, but are not limited to:

- Use of operating room, recovery room, emergency room, treatment rooms and related equipment.
- Drugs and medicines, biologics (medicines made from living organisms and their products), and pharmaceuticals.
- Dressings and supplies, sterile trays, casts, and splints.
- Diagnostic and therapeutic services.
- Blood processing and transportation and blood handling costs and administration.

Anesthesia — the loss of normal sensation or feeling. There are two different types of anesthesia:

- General anesthesia, also known as total body anesthesia, causes the patient to become unconscious or "put to sleep" for a period of time.
- Local anesthesia causes loss of feeling or numbness in a specific area usually injected with a local anesthetic drug such as Lidocaine.

Anniversary date — the annual date on which a group renews its coverage.

Anthem Blue Cross and Blue Shield — Rocky Mountain Hospital and Medical Service, Inc., a Colorado insurance company doing business as Anthem Blue Cross and Blue Shield. Also referred to as "Anthem."

Appeal — a process for reconsideration of Anthem's decision regarding a member's claim.

Authorization — approval of benefits for a covered procedure or service.

Benefit period — the number of days or units of service, such as two office visits per member's benefit year, for which Anthem will provide benefits during a specified length of time.

Billed charges — a provider's regular charges for services and supplies, as offered to the public generally and without any adjustment for any applicable PPO, participating provider or other discounts.

Biologically based mental illnesses — are schizophrenia, schizo-affective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder and panic disorder.

Birth abnormality — a condition that is recognizable at birth, such as a fractured arm.

Birthday rule — the guideline that determines which of two parents' health insurance coverages is primary for the coverage of dependent child(ren). Generally, under the birthday rule, the parent whose birthday comes first during the year is considered to have the primary insurance coverage for the child(ren). Any balance may be submitted to the other parent's insurance carrier for additional consideration.

Care management — a plan of medically necessary and appropriate health care, which is aimed at promoting more effective interventions to meet member needs and optimize care. Care management is also referred to as case management.

Care manager — a professional (e.g., nurse, doctor or social worker) who works with members, providers and Anthem to coordinate services deemed medically necessary for the member. A care manager is also referred to as a case manager.

Certificate — this document, which explains the benefits, limitations, exclusions, terms and conditions of the health coverage.

Chemotherapy — drug therapy administered as treatment for malignant conditions and diseases of certain body systems.

Chiropractic services — a system of therapy in which disease is considered the result of abnormal function of the nervous system. This method of treatment usually involves manipulation of the spinal column and other body structures.

Chronic Pain — ongoing pain that lasts more than six months that is due to non-life threatening causes, may continue for the remainder of the person's life, and has not responded to current available treatment methods.

COBRA — an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law allows individuals, in certain cases, to continue their group health insurance coverage for a specified period after termination of their employment for other qualifying events.

Coinsurance — a provision under which the subscriber and Anthem share costs incurred after the deductible is met, according to a specific formula. The amount of coinsurance the member pays to a provider is calculated after the determination of the maximum benefit allowance, but before Anthem subtracts any discount(s) Anthem may have negotiated with the provider.

Cold therapy — application of cold to decrease swelling, pain or muscle spasm.

Complaint — an expression of dissatisfaction with Anthem's services or the practices of an in-network provider, whether medical or non-medical in nature.

Congenital defect – a defect or anomaly existing before birth, such as cleft lip or club foot. Disorders of growth and development over time are not considered congenital.

Consultation/second opinion — a service provided by another physician who gives an opinion about the treatment of the member's condition. The consulting physician often has specialized skills that are helpful in diagnosing or treating the illness or injury.

Coordination of benefits — also known as COB, a stipulation in most health insurance policies that helps prevent duplicate payments for services covered by more than one policy or program of insurance. For example, a member may be covered by the member's own policy, as well as a spouse's policy. Eligible medical expenses are covered first by a person's own policy. Any balance is submitted to the spouse's health insurance carrier for additional consideration.

Copayment — the portion of a claim or medical expense that a member must pay out of the member's own pocket to a provider or a facility for each service. A copayment is usually a fixed amount that is paid at the time the service is rendered.

Cosmetic services — beautification procedures, services or surgery of a physical characteristic to improve an individual's appearance.

Cost sharing — the general term for out-of-pocket expenses, e.g., copayments and deductibles, paid by a member.

Covered services — supplies or treatments which are:

- Medically necessary or otherwise specifically included as a benefit under this certificate.
- Within the scope of the license of the provider performing the service.
- Rendered while coverage under this certificate is in force.
- Not experimental/investigational or otherwise excluded or limited by the certificate, or by any amendment or rider thereto.
- Authorized in advance by Anthem if such preauthorization is required by the certificate.

Creditable coverage — a qualified prior health coverage that an employee and/or dependent had within 90 days prior to the effective date of Anthem's coverage. Prior creditable health coverage includes Medicare or Medicaid coverage, a group health insurance coverage, an individual health benefit coverage, state high risk pool coverage, any federal or state health benefit coverage or any other health benefit coverage that provides basic medical and hospital care, including, but not limited to, hospital services, physicians' services, outpatient medical services, and laboratory and X-ray services.

Cryocuff — water-circulating pad with pump. A machine that circulates fluid through a specially designed pad to provide continuous cold or heat therapy to a specific area.

Custodial care — care provided primarily to meet the personal needs of the member. This includes help in walking, bathing or dressing. It also includes, but is not limited to, preparing food or special diets, feeding, administration of medicine that is usually self-administered or any other care which does not require continuing services of specialized medical personnel.

Deductible — an amount that is required to be paid by a subscriber before Anthem will begin to reimburse for services.

Dental services — services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Discharge planning — the evaluation of a member's medical needs and arrangement of appropriate care after discharge from a facility.

Durable medical equipment — any equipment that can withstand repeated use, is made to serve a medical condition, is useless to a person who is not ill or injured, and is appropriate for use in the home.

Effective date — the date coverage under this certificate begins.

Elective surgery — a procedure that does not have to be performed on an emergency basis and can be reasonably delayed. Such surgery may still be considered medically necessary.

Emergency —the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Employer master contract — the agreement between Anthem and the employer stating all of the terms and provisions applicable to group coverage. The final interpretation of any specific provision contained in this certificate is governed by the employer master contract.

Experimental/investigational — (a) Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease,

injury, illness or other health condition which Anthem determines in its sole discretion to be experimental or investigational.

Anthem will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be experimental or investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency, and such final approval has not been granted.
- Has been determined by the FDA to be contraindicated for the specific use.
- Is provided as part of a clinical research protocol or clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as experimental/investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

(b) Any service not deemed experimental or investigational based on the criteria in subsection (a) may still be deemed to be experimental or investigational by Anthem. In determining whether a service is experimental or investigational, Anthem will consider the information described in subsection (c) and assess all of the following:

- Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes
- Whether the evidence demonstrates that the service improves the net health outcomes of the total population for whom the service might be proposed as any established alternatives
- Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(c) The information Anthem considers or evaluates to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational under subsections (a) and (b) may include one or more items from the following list, which is not all-inclusive:

- Randomized, controlled, clinical trials published in authoritative, peer-reviewed United States medical or scientific journal
- Evaluations of national medical associations, consensus panels and other technology evaluation bodies
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- Documents of an IRB or other similar body performing substantially the same function
- Consent documentation(s) used by the treating physicians, other medical professionals or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- The written protocol(s) used by the treating physicians, other medical professionals or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- Medical records
- The opinions of consulting providers and other experts in the field

(d) Anthem has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational.

Explanation of benefits — also known as an EOB, a printed form sent by an insurance company to a member after a claim has been filed and adjudicated. The EOB includes such information as the date of service, name of provider, amount covered and patient balance. An explanation of Medicare benefits, or EOMB, is similar, except it is sent following submission of a Medicare claim.

Family membership — a membership that covers two or more persons (the subscriber and one or more dependents).

Grievance — a written complaint about the quality of care, denial of a benefit or service received from a provider.

Health Plan Description Form — the state regulated document, found in the front of the certificate, which identifies the type of coverage, copayment, deductible and coinsurance information.

Health benefit ID card — the card Anthem gives members with information such as the subscriber's name, number and date issued.

Hemodialysis — the treatment of an acute or chronic kidney ailment during which impurities are removed from the blood with dialysis equipment.

Holistic medicine — various preventive and healing techniques, that are theoretically based on the influence of the external environment and the various ways different body tissues affect each other along with the body's natural healing powers.

Home health agency — An agency certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVIII of the Federal "Social Security Act," as amended, for home health agencies. A home health agency is primarily engaged in arranging and providing nursing services, home health aide services, and other therapeutic and related services.

Home health care — the special term for skilled nursing, occupational therapy and other health-related services provided at home by a certified home health agency.

Home health services — the following services provided by a certified home health agency under a plan of care to eligible members in their place of residence: professional nursing services; certified nurse aide services; medical supplies, equipment, and appliances suitable for use in the home; and physical therapy, occupational therapy, speech pathology and audiology services.

Hospice agency — an agency licensed by the Colorado Department of Public Health and Environment to provide hospice care in this state. A hospice is a centrally administered program of palliative, supportive and interdisciplinary team services providing physical, psychological, spiritual and sociological care for terminally ill individuals and their families within a continuum of inpatient care, home health care and follow-up bereavement services available 24 hours a day, seven days a week.

Hospice care — an alternative way of caring for terminally ill individuals that stresses palliative care rather than curative or restorative care. Hospice care focuses on the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the member. Hospice care addresses physical, social, psychological and spiritual needs of the member and the member's family.

Hospital — a health institution offering facilities, beds and continuous services 24 hours a day and meets all licensing and certification requirements of local and state regulatory agencies.

Individual membership — a membership covering one person (the subscriber).

In-network — a term for providers or facilities that enter into a network agreement with Anthem.

Inpatient medical rehabilitation — care that includes a minimum of three hours of therapy, e.g., speech therapy, respiratory therapy, occupational therapy and/or physical therapy, and often some weekend therapy. Inpatient medical rehabilitation is generally provided in a rehabilitation section of a hospital or a freestanding facility. Some skilled nursing facilities have "rehabilitation" beds.

Intractable pain — a pain state in which the cause of the pain cannot be removed and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found

after reasonable efforts, including, but not limited to, evaluation by the attending physician and one or more physicians specializing in the treatment of the area, system or organ of the body perceived as the source of the pain.

Laboratory and pathology services — testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material that has been removed from the body.

Long-term acute care facility— an institution that provides an array of long term critical care services to members with serious illnesses or injuries. Long term acute care is provided for patients with complex medical needs. These include high-risk pulmonary patients with ventilator or tracheotomy needs, medically unstable members, extensive wound care or post operative surgery wound members, and low level closed head injury members. LTAC facilities do not provide care for low intensity patient needs.

Managed care — a system of health care delivery the goal of which is to give members access to quality, cost effective health care while optimizing utilization and cost of services, and measuring provider and coverage performance.

Maternity services — services required by a member for the diagnosis and care of a pregnancy (excluding over-the-counter products) and for delivery services. Delivery services include:

- Normal vaginal delivery.
- Caesarean section delivery.
- Spontaneous termination of pregnancy prior to full term.
- Therapeutic or elective termination of pregnancy prior to viability.
- Complications of pregnancy.

Maximum benefit allowance — the maximum dollar amount determined and approved by Anthem which Anthem allows for covered services and procedures. Anthem's determination of a maximum benefit allowance is the maximum amount Anthem approves for any particular service. Cost sharing amounts are based on this allowance and on the allowance and are the amounts the member pays to a provider.

Maximum medical improvement — a determination at Anthem's sole discretion that no further medical care can reasonably be expected to measurably improve a member's condition. Maximum medical improvement shall be determined without regard to whether continued care is necessary to prevent deterioration of the condition or is otherwise life sustaining.

Medically necessary — an intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that Anthem solely determines to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.
- Obtained from a physician and/or licensed, certified or registered provider.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost).
- Not experimental/investigational.
- Not primarily for the convenience of the member, the member's family or the provider.
- Not otherwise subject to an exclusion under this certificate.

The fact that a physician and/or provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies medically necessary.

Medical supplies — items (except prescription drugs) required for the treatment of an illness or injury.

Medicare — a federally funded health insurance program that provides benefits for people age 65 and older. Some individuals under age 65 who are disabled or who have end stage kidney disease also are eligible for Medicare benefits.

Member — the subscriber or any dependent who is enrolled for coverage under this certificate.

Member's benefit year — The member's benefit year begins on the subscriber's effective date, and expires on the following December 31; a new member's benefit year commences on each subsequent January 1.

Mental health condition — non-biologically based mental conditions with a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition (e.g., depression secondary to diabetes or primary depression).

Myotherapy — the physical diagnosis, treatment and pain management of conditions which cause pain in muscles and bones.

Nephritis — infection or inflammation of the kidney.

Nephrosis — condition in which there are degenerative changes in the kidneys without the occurrence of inflammation.

Non-participating provider — a provider defined as one of the following:

- A facility provider, such as a hospital, that has not entered into an agreement with Anthem
- A professional provider, such as a physician, who has not entered in to an agreement with Anthem
- Providers who have not contracted or affiliated with Anthem's designated subcontractor(s) for the services they perform under this certificate

Occupational therapy — the use of educational and rehabilitative techniques to improve a member's functional ability to live independently. Occupational therapy requires that a properly accredited occupational therapist (OT) or certified occupational therapy assistant (COTA) perform such therapy.

OMT — an acronym for Osteopathic Manipulative Therapy, a hands-on modality of evaluation, diagnosis, and treatment using palpation of the body's tissues and musculoskeletal system with a variety of therapuetic techniques involving fascia, muscles, and joints to help resolve both acute and chronic musculoskeletal injuries.

Open enrollment — the 31 days prior to a group's anniversary date. During this period, members may enroll themselves and their dependents for coverage or change coverage, if this option is available.

Organ transplants — a surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of body substances, such as stem cells or bone marrow, for the purpose of treatment and reimplanting the removed organ or tissue into the same person.

Orthopedic appliance — a rigid or semi-rigid support used to eliminate, restrict or support motion in a part of the body that is diseased, injured, weak or malformed.

Orthotic — a support or brace for weak or ineffective joints or muscles.

Out-of-network — a term for providers or facilities that do not enter into a network agreement with Anthem, usually at a higher out-of-pocket expense to members than services rendered by an in-network provider.

Out-of-pocket annual maximum— the cost sharing total a member may be liable for under this certificate for medical expenses during a specified period. The out-of-pocket annual maximum is designed to protect members from catastrophic health care expenses. For each member's benefit year, after the out-of-pocket annual maximum is reached, for most services payment will be made at 100 percent of the allowable charge for the remainder of the member's benefit year.

Outpatient medical care — non-surgical services provided in a provider's office, the outpatient department of a hospital or other facility, or the member's home.

Paraprofessional — a trained colleague who assists a professional person, such as a radiology technician.

Participating provider — a facility provider (such as a hospital) or a professional provider (such as a physician) that has entered into an agreement with Anthem or another Blue Cross and Blue Shield Plan to bill Anthem directly for covered services, and to accept Anthem's maximum benefit allowance as the maximum amount of payment for covered services the participating provider must bill the member for or use to calculate cost sharing amounts for covered services.

Physical therapy — the use of physical agents to treat disability resulting from disease or injury. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage and therapeutic exercise. Physical therapy must be performed by a physician or registered physical therapist.

Physician — A doctor of medicine or osteopathy who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

PPO provider — a participating facility provider or a participating professional provider that has entered into an additional agreement with Anthem, to limit charges for services performed under this certificate.

Preauthorization —a process in which requests for services are reviewed prior to service for approval of benefits, length of stay and appropriate location.

Premium — monthly charges that the member and/or group must pay to establish and maintain coverage.

Prescription drugs — prescription drugs include:

Brand name prescription drug — the initial version of a medication developed by a pharmaceutical manufacturer or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires and FDA requirements are met, any manufacturer can produce the drug and sell the drug under its own brand name or under the drug's chemical (generic) name. Anthem will designate brand name prescription drugs as follows:

- As a formulary brand name prescription drug identified on the formulary by Anthem as a prescription drug with a tier-2 copayment as listed on the *Health Plan Description Form*.
- As a non-formulary brand name prescription drug **not** identified on the formulary by Anthem as a prescription drug with a Tier-3 copayment as listed on the *Health Plan Description Form.*

Legend drug — a medicinal substance, dispensed for outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications that contain at least one such medicinal substance are considered to be prescription legend drugs. Insulin is considered a prescription legend drug under this certificate.

Formulary — a list of pharmaceutical products developed in consultation with physicians and pharmacists and approved for their quality and cost effectiveness.

Generic prescription drug — drugs determined by the FDA to be bio-equivalent to brand name drugs and that are not manufactured or marketed under a registered trade name or trademark. A generic drug's active ingredients duplicate those of a brand name drug. Generic drugs must meet the same FDA specifications as brand name drugs for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, and cream) as the counterpart brand name drug. On average, generic drugs cost about half as much as the counterpart brand name drug. Generic prescription drugs are identified on the formulary by Anthem as prescription drugs with a tier-1 copayment as listed on the *Health Plan Description Form.*

Pharmacy — an establishment licensed to dispense prescription drugs and other medications through a licensed pharmacist upon a authorized health care professional's order. A pharmacy may be an in-network provider or an out-of-network provider. An in-network pharmacy is contracted as an in-network pharmacy with Anthem to provide covered drugs to members under the terms and conditions of this certificate. An out-of-network pharmacy is **not** contracted with Anthem.

Preauthorization — the process applied to certain drugs and/or therapeutic categories to define the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the pharmacy and therapeutics committee.

Preventive care — comprehensive care that emphasizes prevention, early detection and early treatment of conditions through routine physical exams, immunizations and health education.

Private-duty nursing services — services that require the training, judgment and **technical** skills of an actively practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.). Such services must be prescribed by the attending physician for the **continuous** medical treatment of the condition.

Prostate screening —testing to identify an increased risk of prostate cancer in the absence of any abnormal symptoms.

Prosthesis — a device that replaces all or part of a missing body part.

Provider — a person or facility recognized by Anthem as a health care provider and that fits one or more of the following descriptions:

Professional provider — a physician or other professional provider who is licensed or otherwise authorized by the state or jurisdiction where services are provided to perform designated health care services. For benefits to be payable, services of a provider must be within the scope of the authority granted by the license and covered by this certificate. Such services are subject to review by a medical authority appointed by Anthem. Other professional providers include, among others, certified nurse midwives, dentists, optometrists and certified registered nurse anesthetists. Services of such a provider must be among those covered by this certificate and are subject to review by a medical authority appointed by Anthem.

Facility provider — there are two types of facility providers, inpatient and outpatient.

- Inpatient facility provider — a hospital, alcoholism treatment center, residential treatment center, hospice facility, skilled nursing facility or other facility which Anthem recognizes as a health care provider. These facility providers may be referred to collectively as a facility provider **or** separately as an alcoholism treatment center provider.
- Outpatient facility provider — a dialysis center, Veteran's Administration or Department of Defense hospital, home health agency or other facility provider (except a hospital, alcoholism treatment center or hospice facility, skilled nursing facility or residential treatment center) recognized by Anthem and licensed or certified to perform designated health care services by the state or jurisdiction where services are provided. Services of such a provider must be among those covered by this certificate and are subject to review by a medical authority appointed by us. Example: ambulatory surgery center.

Radiation therapy — X-ray, radon, cobalt, betatron, telocobalt, radioactive isotope treatment and similar treatments for malignant diseases and other medical conditions.

Reconstructive breast surgery — a surgical procedure performed following a mastectomy on one or both breasts to re-establish symmetry between the two breasts. The term includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastoplasty.

Reconstructive surgery — surgery that restores or improves bodily function to the level experienced before the event which necessitated the surgery or, in the case of a congenital defect, to a level considered normal. Such surgery may have a coincidental cosmetic effect.

Referral — authorization given to a member to visit another provider.

Resident — an individual who maintains legal domicile within the state of Colorado and is presumed, for purposes of this agreement, to be a primary resident of the state, as evidenced by any three of the following:

- Payment of Colorado income tax
- Employment in Colorado, other than that normally provided on a temporary basis to students
- Ownership of residential real estate property in Colorado
- State identification card or driver's license
- Acceptance of future employment in the state of Colorado
- Vehicle registered in Colorado

- Voter registration in Colorado
- Phone bill or utility bill from Colorado

Room expenses — expenses that include the cost of the room, general nursing services and meal services for the member.

Second opinion — a visit to another professional provider (following a first visit with a different provider) for review of the first provider's opinion of proposed surgery or treatment.

Second surgical opinion — a mechanism used by managed care organizations to reduce unnecessary surgery by encouraging individuals to seek a second opinion prior to specific elective surgeries. In some cases, the health coverage may require a second opinion prior to a specific elective surgery.

Skilled nursing care facility —an institution that provides skilled nursing care (e.g. therapies and protective supervision) for uncontrolled, unstable or chronic condition members. Skilled nursing care is provided under medical supervision to carry out nonsurgical treatment of chronic diseases or convalescent stages of acute diseases or injuries. Skilled nursing facilities do not provide care for high intensity member medical needs, or members that are medically unstable.

Special care units —special areas of a hospital with highly skilled personnel and special equipment to provide acute care, with constant treatment and observation.

Speech therapy (also called speech pathology) — services used for diagnosis and treatment of speech and language disorders. A licensed and accredited speech/language pathologist must perform speech therapy.

Spouse — a subscriber's legal spouse.

Sub-acute medical care — medical care that requires less care than a hospital but often more care than a skilled nursing facility. Sub-acute medical care can be in the form of "transitional care" when a member's condition is improving, but the member is not ready for a skilled nursing facility or home health care.

Sub-acute rehabilitation — care that includes a minimum of one hour of therapy when a member cannot tolerate or does not require three hours of therapy a day. Sub-acute rehabilitation is generally provided in a skilled nursing facility.

Subscriber — the member in whose name the membership with Anthem is established.

Surgery — any variety of technical procedures for treatment or diagnosis of anatomical disease or injury, including, but not limited to cutting, microsurgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, and other invasive procedures. Covered surgical services also include usual and related anesthesia and pre- and post-operative care, including recasting.

Surgical assistant —an assistant to the primary surgeon for required surgical services provided during a covered surgical procedure. Anthem, at its sole discretion, determines which surgeries do or do not require a surgical assistant.

Ultrasound — a radiology imaging technique that uses high frequency sound waves to see organs or the fetus in a pregnant woman.

Urgent care — care provided for individuals who require immediate medical attention but whose condition is not life-threatening (non-emergency).

Utilization management —a process of integrating review of medical services and care management in a cooperative effort with other parties, including patients, physicians, and other health care providers and payers.

Utilization review — a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of, health care services, procedures or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, care management, discharge planning and/or retrospective review. Utilization review also includes reviews to determine coverage. This is based on whether or not a procedure or treatment is considered experimental/investigational in a given

circumstance (except if it is a specific certificate exclusion), and review of a member's medical circumstances when necessary to determine if an exclusion applies in a given situation.

Well-child visit — a physician visit that includes the following components: an age-appropriate physical exam, history, anticipatory guidance and education (e.g., examining family functioning and dynamics, injury prevention counseling, discussing dietary issues, reviewing age-appropriate behaviors, etc.), and assessment of growth and development. For older children, a well-child visit also includes safety and health education counseling.

X-ray and radiology services — services including the use of radiology, nuclear medicine and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

Index

Welcome

We are pleased to welcome you as a Member of an Anthem Blue Cross and Blue Shield **Group Vision Plan**. You have enrolled in a high-quality program. This Membership Certificate is a guide to your coverage. Keep it in a convenient place for quick reference.

This Certificate has been prepared by us to help explain your vision care coverage. Please refer to this Certificate whenever you require vision services. It describes how to access vision care, what vision services are covered by us, and what portion of the vision costs you will be required to pay.

The coverage described in this Certificate is subject in every respect to the provisions of the Master Contract issued to the Group. The Master Contract and this Certificate and any amendments or riders attached to the same, shall constitute the Master Contract under which Covered Services and supplies are provided by us.

This Certificate should be read in its entirety. Since many of the provisions of this Certificate are interrelated, you should read the entire Certificate to get a full understanding of your coverage.

Many words used in the Certificate have special meanings. These words appear in capitals and are defined for you. Refer to these definitions in the **Definitions** section for the best understanding of what is being stated.

This Certificate also contains **Exclusions,** so please read your Certificate carefully.

An additional benefit of your vision coverage is the backing of Anthem Blue Cross and Blue Shield.

Caroline Matthews
Chief Operating Officer
Anthem Blue Cross and Blue Shield

Introduction

Services and Benefits

If your vision care is rendered by a Network Provider, benefits will be provided at the Network level. Refer to the Schedule of Benefits. No benefits will be provided for care that is a Covered Service even if performed by a Network Provider.

We may inform you that it is not Medically Necessary for you to receive services. This decision is made upon review of your condition and treatment. We have final authority to determine the Medical Necessity of the service. You may appeal this decision. See Complaint Procedure in the How to File Claims in Appeals section of this Certificate.

Network Providers are Professional Providers and other facility Providers who contract with us to perform services for you. You will not be required to file any claims for services you obtain directly from Network Providers.

Non-Network Services

Vision services that are not obtained from a Network Provider will be considered a Non-Network Service. In addition, certain services may not be covered unless obtained from a Network Provider, and/or may result in higher cost-share amounts. See your Schedule of Benefits. You will be required to file claims for covered services you obtain directly from a Non-Network Provider.

Relationship of Parties (Plan - Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Provider or in any Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or cost sharing relationships related to provision of services or referrals to other Providers, including Network and Non-Network Providers. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Certificate does not give anyone any claim, right, or cause of action against the Plan based on what a Provider of vision care, services or supplies, does or does not do.

Definitions

This section defines certain words used throughout the Certificate. The first letter of each of these words will be capitalized whenever it is used as defined below in this text. Reading this section will help you understand the rest of the Certificate. You may also wan to refer back to this section to find out exactly how — for the purposes of this Certificate — a word is used.

Anthem Blue Cross and Blue Shield (Plan) — Means Rocky Mountain Hospital and Medical Service, Inc., a Colorado insurance company doing business as Anthem Blue Cross and Blue Shield (also referred to as Anthem BCBS).

NOTE: "We," "our," and "us" refer to Anthem Blue Cross and Blue Shield or Anthem BCBS.

Benefit Year – The Benefit Year is a calendar year: from January 1 through December 31 of the same year. The initial Benefit Year is from a member's effective date through December 31 of the same year. (A member's initial Benefit Year may be less than 12 months.) If your coverage ends earlier, the benefit year ends at the same time.

Certificate (Membership Certificate) — This document, which explains the benefits, limitations, exclusions, terms, and conditions of your health coverage.

Copayment - A specific dollar amount or percentage of the Maximum Allowable Amount for Covered Services indicated in the Schedule of Benefits for which you are responsible.

Covered Services - Services and supplies or treatment as described in the Certificate. To be considered Covered Services, services must be:

- Medically Necessary or otherwise specifically included as a benefit under this Certificate
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Certificate is in force;
- Not experimental or investigational or otherwise excluded or limited by the Certificate, or by any amendment or rider thereto.
- Authorized in advance by Anthem if such preauthorization is required in the Certificate.
- A Covered Service is incurred on the date the service, supply or treatment was provided to you.

Deductible - The dollar amount of Covered Services listed in the Schedule of Benefits for which you are responsible before we start to pay for Covered Services each Benefit Year.

Elective Contact Lenses - All contact lenses that are not Medically Necessary Contact Lenses.

Maximum Allowable Amount - The amount that we determine is the maximum amount payable for Covered Services you receive based on the established fee schedule. The Maximum Allowable Amount is subject to any Copayments, limitations or Exclusions listed in this Certificate.

For a Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the Maximum Allowable Amount. We will reimburse up to the Non-Par Reimbursement schedule identified in the Summary Plan Description.

For a Non-Network Provider who is a physician or other non-facility Provider, even if the Provider has a participation agreement with us for another product, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for this Product.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its agreement with us.

Medically Necessary or Medical Necessity - Services or supplies received for the treatment of an illness or injury or other health condition that is determined by us to be:

- Appropriate and consistent with the diagnosis or symptoms, and consistent with accepted standards of practice;
- Not experimental/investigative or unproven;
- Not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment; and
- Not provided only as a convenience to you, your physician, or another Provider or person.

The fact that any particular Provider may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such treatment Medically Necessary. We have the final authority for determining the Medical Necessity of Covered Services.

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by us, or with another organization which has an agreement with us, to provide Covered Services and certain administration functions for the Network associated with this Certificate.

Non-Network Provider - A Provider who has not entered into a contractual agreement with us for the Network associated with this Certificate. Providers who have not contracted or affiliated with our designated Subcontractor(s) for the services they perform under this Certificate are also considered Non-Network Providers.

Ophthalmology —a branch of medical science dealing with the structure, function, and diseases of the eye. An ophthalmologist must be licensed to practice ophthalmology.

Optometry — an examination of the eye for defects or faults in refraction and the prescribing of correctional lenses or exercises. An optometrist must be licensed to practice optometry.

Provider - A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that we approve. This includes any Provider rendering services, which are required by applicable state law to be covered when rendered by such Provider.

Subcontractor - Anthem may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on our behalf.

Membership Eligibility, Enrollment, Changes, and Termination

See the medical plan certificate under the heading **MEMBERSHIP** for information on eligibility, enrollment, changes and termination.

Conversion

Conversion coverage is not available under this Vision Certificate.

What We Will Pay For — Benefits

This section describes the Covered Services available under your vision care benefits when provided and billed by Network Providers. All Covered Services are subject to the exclusions listed in the Exclusions section and all other conditions and limitations of the Certificate. The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Non-Network Provider and whether or not you choose optional services and/or custom materials rather than standard services and supplies. Payment amounts are specified in the Schedule of Benefits.

The following are Covered Services:

- Vision examination when performed by an ophthalmologist or optometrist.

Services obtained through a Non-Network Provider are subject to the same Exclusions and limitations as services through a Network Provider.

What We Will Not Pay For — General Limitations and Exclusions

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary.

The following services are **not** covered services:

- Lens, frames, or contact lens.
- Special procedures such as orthoptics, vision training, or vision aids
- Received from an individual or entity that is not a Provider, as defined in this Certificate.
- Which are experimental or investigative or related to such, whether incurred prior to, in connection with, or subsequent to the experimental or investigative service or supply, as determined by us.
- For any condition, disease, defect, aliment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For illness or injury that occurs as a result of any act of war, declared or undeclared.
- For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- For which you have no legal obligation to pay in the absence of this or like coverage.
- Received from a vision or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.
- Prescribed, ordered, or referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except, as specified elsewhere in this Certificate or as otherwise prohibited by federal law.
- In excess of Maximum Allowable Amount.
- Incurred prior to your Effective Date.
- Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.
- For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a Group, mutual benefit association, labor union, trust, or similar person or group (unless received by a Network provider).
- For inpatient or outpatient hospital vision care.
- For Orthoptics or vision training and any associated supplemental testing.
- For services or supplies not specifically listed in the Certificate.

GENERAL PROVISIONS

Administration

Note: The following provision only applies where the interpretation of this Certificate is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

The Plan, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of this Certificate. This includes, without limitation, the power to construe the Contract and Certificate, to determine all questions arising under this Certificate, and to make, establish and amend the rules and regulations and procedures with regard to the interpretation and administration of the provisions of this Certificate. However, these powers shall be exercised in such a manner that has a reasonable relationship to the provisions of the Contract and Certificate. A specific limitation or Exclusion will override more general benefit language.

Anthem Insurance Companies, Inc.

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Certificate constitutes a contract solely between the Group and Anthem Insurance Companies, Inc. (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Colorado. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Plan, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of vision care services provided under this Certificate is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render services provided under this Certificate insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Clerical Error

Clerical error, whether of the Group or the Plan, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Conformity with State Law

Any provision of this Plan, which is in conflict with the laws of the state in which it is issued, is hereby amended to conform with the minimum requirements of such laws.

Coordination of Benefits

We consider this Plan primary in all circumstances.

Disclaimer of Liability

We have no control over any diagnosis, treatment, care, or other service provided to a Member by any Provider, and we are not liable for any loss or injury caused by any health care Provider by reason of negligence or otherwise.

Entire Contract

This Certificate, the Master Contract, the Group application, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire Contract between the Plan and the Group and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Group and any and all statements made to the Group by the Plan are representations and not

warranties, and no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

Execution of Papers

On behalf of yourself and your Dependents you must, upon request, execute and deliver to us any documents and papers necessary to carry out the provisions of this Certificate.

Form or Content of Certificate

No agent or employee of the Plan or anyone acting on our behalf is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by an officer of the Plan.

Interpretation of Certificate

The laws and regulations of the State of Colorado, which issued the Certificate of Authority to the Plan, shall be applied to the interpretations of this Certificate.

Modifications

By this Certificate, the Group makes the Plan coverage available to eligible Members. However, this Certificate shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Master Contract, or by mutual agreement between the Plan and the Group without the consent or concurrence of any Member. By electing vision coverage under the Plan or accepting the Plan benefits, all Members legally capable of contracting and the legal representatives of all Members incapable of contracting agree to all terms, conditions, and provisions hereof.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under this Certificate shall not duplicate any benefits to which Members are entitled or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

Payment in Error

If we make an erroneous benefit Payment, we may require you, the Provider of services, or the ineligible person to refund the amount paid in error. We reserve the right to correct Payments made in error by offsetting the amount Paid in error against new claims. We also reserve the right to take legal action to correct Payments made in error.

Pilot Programs

We may occasionally develop pilot programs to test different benefits or recognize different Providers. The fact that a pilot program may exist does not guarantee that all Members are eligible for pilot program benefits or that such benefits will be permanent.

Plan's Sole Discretion

The Plan or anyone acting on our behalf, may, at its sole discretion, cover services and supplies not specifically covered by the Certificate. This applies if it is determined such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate with which a Member shall comply.

Relationship of Parties (Group-Member-Plan)

Neither the Group nor any Member is the agent or representative of the Plan.

The Group is fiduciary agent of the Member. The Plan's notice to the Group will constitute effective notice to the Member. It is the Group's duty to notify the Plan of eligibility data in a timely manner. The Plan is not responsible for payment of Covered Services of Members if the Group fails to provide the Plan with timely notification of Member enrollments or termination's.

Right of Recovery

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

Sending Notices

All notices to the Subscriber are considered to be sent to and received by the Subscriber when deposited in the United States mail with postage prepaid and addressed to either:

- The Subscriber at the latest address appearing on our membership records; or
- The Subscriber's employer.

Subscriber's Legal Expense Obligations

You and your Dependents are liable for any actions that may prejudice our rights under this Certificate. If we must take legal action to uphold our rights and prevail in that action, we will be entitled to receive and you agree to pay our legal expenses, including attorney's fees and court costs.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Certificate, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

How To File Claims and Appeals

This section explains how to file claims to obtain benefits, and what to do if you disagree with the action taken on your claim.

How to File Claims

When a Network Provider bills us for Covered Services, we will pay them the appropriate benefit directly. Payment is subject to any applicable Copayment requirements.

If a Non-Network Provider does not bill us directly, you must file your own claim. You must send us your receipt from the Provider and include your member number. Balance due statements, cash register receipts, and cancelled checks are not acceptable. All information on the receipt must be readable. If information is missing on your receipt or is not readable, it will be returned to you.

We are not required to honor an assignment of benefits to Non-Network Providers. We may honor an assignment of benefits to Non-Network Providers at our sole discretion. If we pay you directly, you will be responsible for paying the Non-Network Provider of services for all charges.

Where and When to Send Your Claim

Make copies of the bills for your own records and attach the original bills to the receipt. Submit the receipt (including your member number) to:

Anthem Blue Cross and Blue Shield
555 Middle Creek Parkway
Colorado Springs, Colorado 80921

Your claim must be filed **within 365 days** after the date of service. Any claims filed after this limit may be refused. Failure to file a claim within such time shall not invalidate or reduce any claim if it is shown that it was not reasonably possible to give such notice and that notice was given as soon as reasonably possible.

Your claim will be processed in accordance with the time frame as required by State law for prompt payment of claims.

Notice of Privacy Practices

Anthem is committed to protecting the confidential nature of members' medical information to the fullest extent of the law. In addition to various laws governing member privacy, Anthem has its own privacy policies and procedures in place designed to protect member information. Anthem is required by law to provide individuals with notice of Anthem's legal duties and privacy practices. To obtain a copy of this notice, visit Anthem's website or contact Anthem's customer service department.

Complaints

If you have a **complaint** about any aspect of our service or claims processing, please contact a Customer Service Representative at Anthem Blue Cross and Blue Shield at the phone number listed on your identification card. For purposes of this document, a **grievance** is a complaint about the quality of care or service received from a provider. You may also send a written complaint to the following address:

Anthem Blue Cross and Blue Shield
Customer Service Department
555 Middle Creek Parkway
Colorado Springs, CO 80921

A trained representative will work to clear up any confusion and resolve your difficulties. Your written grievance will be investigated by our Quality Management Department. If you are not satisfied with the decision of Anthem Blue Cross and Blue Shield Customer Service, you may file an appeal as explained below.

Appeals

Definitions

Utilization Review — means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. Utilization review also includes reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance (except if it is a specific certificate exclusion) and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given situation.

If you wish to file an **appeal** regarding a benefit denial based on Utilization Review, you may file an **appeal** without first going through the above complaint process. You may also file an **appeal** after going through the complaint process. To give notice of an **appeal** you must send your request in writing. Your written appeal should outline the problem, describe your previous efforts to resolve the matter, and request another review. Any supporting documents should be enclosed with your letter. The appeal should be addressed as follows:

Anthem Blue Cross and Blue Shield
Appeals Department
555 Middle Creek Parkway
Colorado Springs, CO 80921

To ensure a thorough, unbiased review, you may access two levels of appeal. In the case of a benefit denial based on Utilization Review, an Independent External Review appeal is also available to you.

Level 1 Appeal — This is an **appeal** in which Anthem Blue Cross and Blue Shield appoints an internal person or persons, not involved in the initial determination to review Anthem Blue Cross and Blue Shield's position. However, a person that was previously involved with the denial may answer questions. The person(s) appointed to review a Level 1 Appeal involving Utilization Review issues shall consult with an appropriate clinical person or person's in the same specialty as would typically manage the case being reviewed. For Utilization Review issues, you will receive a response to your appeal within 20 workdays of receipt of your appeal request. Non-utilization review appeals will typically be resolved within 30 workdays.

Level 2 Appeal — This is an **appeal** that has not been resolved to the member's satisfaction under the Level 1 Appeal process. The panel of reviewers shall include a minimum of three people and may be composed of employees of Anthem Blue Cross and Blue Shield who have appropriate professional expertise. A majority of the panel shall be comprised of persons who were not previously involved in the dispute. However, a person who was previously involved with the dispute may be a member of the panel or appear before the panel to present information or answer questions. In the case of utilization review denials, Anthem Blue Cross and Blue Shield shall ensure that a majority of the persons reviewing the appeal are health care professionals who have appropriate expertise. Such reviewing health care professionals shall meet the following criteria:

- Have not been involved in the care previously
- Are not a member of the board of directors of the health plan.
- Have not been involved in the review process for the covered person previously
- Do not have a direct financial interest in the case or in the outcome of the review.

However, a person who was previously involved may be a member of the panel to present information or answer questions. Anthem Blue Cross and Blue Shield shall issue a copy of the written decision to the covered person and to a provider who submits a grievance on behalf of a covered person. Anthem Blue Cross and Blue Shield will make a written response to your appeal within 50 workdays of receipt of your appeal request.

A member or member's representative has the right to request an **expedited appeal** of a Utilization Review decision when the time frames for a standard review would: seriously jeopardize the life or health of the covered person; jeopardize the covered person's ability to regain maximum function; or for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently. Typically the decision will be made within 72 hours. Expedited appeals will be evaluated by an appropriate clinical peer or peers who were not involved in the initial denial. Anthem Blue Cross and Blue Shield will not provide an expedited review for retrospective denials.

Members have the right to participate in person or via conference call in the Level 2 Appeals meetings. Members may be assisted by anyone of their choosing to help them with their appeal.

Independent External Review — These are conducted by independent external review entities, which are selected by the Colorado Division of Insurance. Independent External Review appeals are available only in those circumstances where benefits were denied based on Utilization Review and which have gone through the company's Level 2 Appeal process. To request an independent external review for a Utilization Review denial, you or your representative must complete and submit your written request on a form entitled "Request for Independent External Review of Carrier's Final Adverse Determination". This form is available through the Customer Service Department; see your identification card for the phone number. The request must be made to us within 60 calendar days after the date of receipt of a notice of our Level 2 Appeal denial. The Division of Insurance will assign an independent review entity to conduct the review. The independent reviewer's decision will be made within 30 working days after we receive your request for such a review. This timeframe may be extended up to 10 working days for the consideration of additional material if requested by the reviewer.

Expedited Independent External Review — Expedited reviews may be requested by a covered member or the member's representative if the covered person has a medical condition where the timeframe for a standard external review would: seriously jeopardize the life or health of the covered person; jeopardize the covered person's ability to regain maximum function; or for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently. The covered person's request must include a physician's certification that the person's medical condition meets the criteria for expedited reviews. The request must be made on the form referenced in the paragraph above. Determinations will be made by the independent external review entities within seven working days after we receive your request for an expedited review. This timeframe may be extended for an additional five working days for the consideration of additional information if requested by the reviewer. An expedited external review may not be provided for retrospective denials.

Before legal action is taken on a claim decision, you must follow the appeals process stated above.

Legal Action

Before you take legal action on a claim decision:

You must first follow the appeal process outlined above in **Complaints** and **Appeals.**

You must meet all the requirements of this Membership Certificate.

No action in law or in equity shall be brought to recover on this Certificate prior to expiration of 60 calendar days after written proof of loss has been filed in accordance with the requirements of this Certificate. No such action shall be brought at all unless brought within three years of the time within which written proof of loss has been filed as required by the Certificate.